

**Immigrant Patients and Primary Health Care  
Services in Auckland and Wellington:  
A Survey of Service Providers**

**Nicola North, Sarah Lovell and Andrew Trlin**

**OCCASIONAL PUBLICATION No. 12  
NEW SETTLERS PROGRAMME  
MASSEY UNIVERSITY  
PALMERSTON NORTH  
2006**

*Copyright © 2006 by New Settlers Programme (N. North, S. Lovell and A. Trlin)*

- No part of this report may be reproduced in any form without written permission.
- *All enquiries (in writing) to:*  
New Settlers Programme  
School of Sociology, Social Policy and Social Work  
Massey University  
Palmerston North  
New Zealand
- See our website at: <http://newsettlers.massey.ac.nz>

ISBN: 0-9582511-3-4

ISSN: 1174-9466

## ACKNOWLEDGMENTS

---

This study could not have been successfully completed without the cooperation of the nurses, doctors and other workers in general practices, Plunket services and emergency health services in Auckland and Wellington who completed and returned the survey questionnaire. We are indebted to you for taking the time to do this and for the additional comments you offered to clarify the pressures and difficulties you face in delivering health services to immigrant patients.

Our thanks are also due to Ms Mariane Lennon for summarising and organising qualitative comments, and to Ms Amie Hammond for her work in editing and formatting an initial draft of the report.

The survey reported here is part of the New Settlers Programme, a multi-disciplinary research programme supported (1997 – 2004) by grants from the Foundation for Research, Science and Technology to contribute to knowledge and understanding of the settlement experiences of immigrants and their impact on aspects of New Zealand society.



## EXECUTIVE SUMMARY

---

Major immigration policy changes since 1986 have facilitated a dramatic increase in the diversity of New Zealand's population, particularly in the greater Auckland and Wellington urban areas. A limited number of studies have identified health service difficulties experienced by some of these recent immigrants, as well as health professionals, in the process of adjustment and settlement.

The present study was conducted to identify the impacts and associated implications of the changing immigrant population with respect to the delivery of primary health care services. More specifically, the aims of the study were:

- To describe the impact(s) of the immigrant population, increasing in size and diversity, on primary health services.
- To describe patterns of primary health care service use and demand associated with immigrant patients.
- To identify the language and cultural limitations or difficulties experienced by primary health care services providing care to immigrant patients.
- To identify the resources currently available and needed to effectively provide care for immigrant patients, and the implications for both the training and continuing education of health care professionals.

A mail questionnaire was sent in July 2002 to all general practices and emergency services (public and private) in the greater Auckland and Wellington urban areas and distributed to Plunket services in the same two areas through the Society's distribution system. Of the 411 questionnaires mailed out or distributed, 205 were completed, yielding a response rate of almost 50 percent.

## Results

The respondents were well aware of the presence of recent immigrants among their patients:

- 65 percent perceived "many" and a further 23 percent "several" immigrants among their service patients.
- 63 percent or more perceived such patients among their service users "once or more a week", this level of contact being more prevalent within the greater Auckland urban area than in Wellington (reflecting the distribution and concentration of recent immigrants) and for emergency medical and general practice services (at or above 70 percent) than for Plunket services (50 percent).

A topic of concern in media reports and anecdotal evidence is that immigrants over-use public hospital emergency departments. This survey provided some support for this concern:

- 65 percent of emergency medical service respondents believed that immigrant patients over-use their health service, compared with approximately 10 percent of both general practice and Plunket respondents in relation to their own services.

The pattern of immigration since the early 1990s and the associated challenges, demands and difficulties faced by health services appears to have led the majority of respondents to anticipate pressure from increased immigration:

- 55 percent believed that increased immigration would put “considerable pressure” on their type of service, but felt they “[would] manage with support”. An additional 10 percent, however, indicated the effect would be one of “enormous pressure, we can’t cope”. Plunket respondents were clear leaders in anticipating “considerable” or “enormous” pressure followed by those in emergency services.

The most common countries/regions of origin of recent immigrant patients specified by respondents for their services echoed the diversity arising from changes in immigration policy:

- 48 percent identified Asian countries/regions, 21 percent traditional origins (the United Kingdom, Australia etc.), 18 percent Pacific origins, and the remaining 13 percent a number of other places in Africa, South America and the Middle East.

These origins varied somewhat by urban area and the type of service involved:

- as expected, immigrants from Pacific origins were clearly predominant in the greater Auckland urban area, while recent immigrants from Asia were more prominent among those perceived in the greater Wellington urban area.
- 52 percent of Plunket respondents identified Pacific Islanders as their most commonly seen immigrant patients, while Asians were the most common patients identified by 53 percent of emergency service respondents (especially for private services) along with a high representation for immigrants from the Middle East and Africa (for public services).

These service variations can probably be attributed to factors such as fertility rates (for Pacific migrants using Plunket services) and pre-migration norms and patterns of primary health service access (for Asians and others using emergency services).

The respondents were split on whether immigrants differed from other patients:

- 58 percent felt that the statement “Immigrant patients are *no different* from any other patient” was “mostly” or “definitely” false, but 42 percent thought it was “definitely” or “mostly” true. This perception was associated to some degree with the frequency with which immigrant patients were seen; the more

frequent the contact with immigrants, the greater the percentage who believed that they were “mostly” or “definitely” different from other patients.

Possible reasons for accepting or rejecting the notion of ‘difference’ were initially unclear. In relation to perceptions of the attitudes, expectations and behaviour of immigrants with regard to aspects of the health system, it was found (among those respondents who had formed an opinion) that:

- the majority saw immigrants *as similar* to “other patients” in (a) not expecting admission to hospital, and (b) not being less likely to accept a practitioner’s reassurances, to expect a prescription or the use of high-tech interventions.
- the majority did not think that immigrant patients were “higher users of preventive care”, “frustrated that they [could not] go directly to a specialist” or given to complaining “about the cost of primary health care”.

On the other hand:

- opinion was divided regarding immigrant “frustration at waiting lists”; and
- a substantial minority (27-33 percent) saw immigrants as being dissatisfied with practitioner reassurances, the cost of health care and the procedure of referral for specialist services.

An important feature of respondent perceptions here was the percentage answering “Don’t know”. Perhaps reflecting an inability or reluctance to offer an opinion outside their field of practice or experience, it also seems to indicate a lack of awareness or knowledge concerning the outlook and/or expectations of immigrant patients – a factor that may contribute to a sense of ‘difference’. However, more specific reasons for a perception of ‘difference’ emerged with respect to the difficulties posed by language, communication and culture.

Whether or not immigrant patients were perceived to be different, respondents acknowledged that working with them was interesting but could also be frustrating:

- 96 percent agreed (45 percent “definitely true”, 51 percent “mostly true”) with the statement “I find working with immigrant patients interesting”; and
- 27 percent found “working with immigrant patients frustrating” (5 percent “definitely true”, 22 percent “mostly true”)

The main difficulties experienced in work with immigrants are relatively well known among health service providers and were confirmed by the respondents:

- 92 percent rejected a view that “Less time is needed with immigrant patients than with other patients” (69 percent “definitely false”, 23 percent “mostly false”). The strength of this rejection varied according to primary health service type, and the prevalence of immigrants among a service’s patients (the greater the prevalence of immigrants, the more likely were respondents to believe that the statement was “definitely false”);
- the majority agreed (i.e. “mostly/definitely true”) that: for “at least once a month” communication with patients who were non-English speakers or

whose English was limited was “time consuming” (78 percent) and “stressful or frustrating” (58 percent);

- the majority also agreed that, for “at least once a month”, there were “instances” with immigrants where they: believed that a patient had “not followed instructions because of communication problems” (62 percent); were uncertain that a patient had understood what was said (74 percent); and where they themselves were “unable to understand what the... patient was saying” (64 percent). In some cases this agreement varied in relation to different factors such as the prevalence of immigrant patients and the types of primary health services.
- Finally, pointing to their recognition of difficulties arising from cultural differences, most respondents agreed that immigrants: “express their concerns and symptoms differently” (70 percent); and “express their pain differently” (51 percent). The percentage either disagreeing or replying “Don’t know” to each statement (30 and 49 percent, respectively), however, should be treated as a matter of concern.

Referring to professionals in their own service and the adequacy of professional preparation for work with patients (a) speaking languages other than English or with limited English, and (b) whose cultures are different, the majority of the respondents:

- rejected the *absence* of a problem (81 percent in each case);
- acknowledged the need for continuing education (69 and 71 percent, respectively);
- rejected statements claiming that the employer provided opportunities to develop or improve skills (76 and 68 percent, respectively); and
- rejected statements claiming that the subject in question was taught or included in professional education (61 and 52 percent, respectively).

The majority of the respondents were dissatisfied with the resources available for work with immigrants. In response to the statement “Health services like this one are *not* adequately resourced to meet the demands of immigrant patients”:

- 61 percent believed it to be “definitely” or “mostly” true, the percentage being higher among Plunket respondents (71 percent) than those in other services.

Given the language and communication difficulties experienced, resources in this area could be expected to be a point of concern. It was found that:

- although 81 percent of the respondents reported the provision of written information/pamphlets in languages other than English, such material was not provided by a substantial percentage of services with a higher prevalence of immigrants (i.e. “several” or “many”) among their patients;
- although 66 percent of respondents reported the use of interpreter services (10 percent indicated the need had not arisen), the types most commonly employed were patient-arranged interpreters (70.4 percent) and a health



service staff member (57.6 percent). The use of either a professional interpreter or a telephone service was limited (16.7 and 9.1 percent, respectively).

Two points should be noted with regard to these findings. First, gaps in the provision of written material were explained in part by the unavailability or limited availability of publications in the languages required. Second, the heavy reliance on non-professional interpreting services was strongly attributed to the cost involved. In fact, only 15 (11.4 percent) of the 132 health care services using some form of interpreter service paid for the service as a budget line item.

Immigrant staff (because of their ability – real or assumed – to directly provide and/or interpret for members of their own ethnic group and to educate or train other service staff) are clearly an important health service resource. It was found that:

- most respondents (55.5 percent) reported having business partners or other staff who were recent immigrants, the percentage varying by service type;
- most immigrant staff were employed as nurses (40 percent) and doctors (24 percent), with the remainder (36 percent) in either non-traditional health roles or administration;
- 77 percent of respondents in services with immigrant staff reported that they were used for communication with non-English speaking patients, the percentage being higher for Plunket (88 percent) than for other services.

Although supporting their employment, some respondents were concerned that immigrant staff could be exposed to excessive demands and pressures as their linguistic and/or cultural skills were exploited by service personnel and members of their own ethnic groups.

## **Recommendations**

The following aspects are in need of attention or consideration by the stakeholders concerned.

### ***For health and immigration services***

- Increased funding to allow for the greater time, professional interpreter services and printed information/pamphlets that are needed by primary health services in order to work more effectively with immigrant patients.
- Alignment of the services available to immigrant patients with the rights set out in the Code of Health and Disability Services Consumers' Rights.
- Further research to determine why immigrants appear to make more use of emergency medical services (including the costs of other primary health services in relation to incomes) in order to reduce the pressure on emergency services.

*For health professionals*

- Increased attention to cross-cultural health care, communication and cultural competence topics (i.e. beyond established provisions for Maori and Pacific peoples) in all basic and continuing educational programmes for health professionals to reflect the increasing diversity of New Zealand's population.

*For language and ethnic communities*

- Further research on and monitoring of the difficulties that immigrant patients experience in using health services, to enable problem areas to be identified and addressed.

# Contents

	Page
<b>Acknowledgments</b>	<b>iii</b>
<b>Executive Summary</b>	<b>v</b>
<b>Introduction</b>	<b>1</b>
Immigration and ethnic diversity	2
Recent research: a selective review	3
Conclusion	5
<b>Methodology</b>	<b>6</b>
Study design	6
Response rates	8
Respondent description	9
<b>Survey Results</b>	<b>10</b>
Perceived service use by immigrants	10
Perception of immigrant patients	13
Perceptions of immigrant demands on services	16
Impact of language, communication and culture	19
Health professional preparation	22
Resourcing service providers for work with immigrants	24
<b>Summary and Recommendations</b>	<b>30</b>
Summary	30
Recommendations	36
<b>References</b>	<b>38</b>
<b>Appendices</b>	<b>43</b>
Appendix 1      Information sheet	44
Appendix 2      Questionnaire	46
<b>Authors</b>	<b>57</b>
<b>Selected New Settlers Programme Publications</b>	<b>58</b>



# INTRODUCTION

---

In 1986, the Minister of Immigration presented a new immigration policy that featured several significant changes, including the abolition of national origin as a factor of selection. Rather than select immigrants by country of birth or citizenship (with a traditional bias toward the United Kingdom, Ireland and other countries in north-west Europe) they were now to be assessed on criteria that evaluated the prospective migrant's "personal qualities, skills, qualifications, potential contribution [to New Zealand] and capacity to settle well" (Trlin, 1992: 4). Further policy changes were introduced in the 1990s to encourage the immigration of skilled workers, professionals and business migrants. The 'points system', introduced in 1991 and amended in 1995, focused upon the recruitment of human capital for New Zealand's economic development in the context of a competitive global economy and favoured younger applicants (20-40 years of age) with tertiary educational qualifications, work experience and funds for settlement and/or investment (see Trlin, 1997). Together with the earlier removal of national origin, the new criteria facilitated a dramatic increase in the diversity of New Zealand's population as large numbers of immigrants from Asia (notably the growing urban middle classes of Taiwan, South Korea, Malaysia, Singapore, India, Hong Kong and mainland China) exercised their eligibility for residence along with a strong flow from South Africa and continuing arrivals from more traditional sources. During the 1990s, New Zealand also continued to be a favoured destination for South Pacific migrants and maintained its humanitarian role in the resettlement of refugees, among them being those from Somalia, Bosnia and Kosovo.

Rapid changes in the size and composition of a population because of international migration invariably produce stresses and strains at the interface between clients and various public and private services. Responding to these pressures in New Zealand, professionals engaged in fields such as psychology (Curren, 1997; Gherardi and Tanoi, 1997; Aye and Guerin, 2001), counselling (Wilson and Everts, 1995), education (Whyte, 1995; Hill and Hawk, 1998; Penton et al., 2000; Hall and Bishop, 2001) and social work (Briggs, 2001; Selvaraj, 2001) have begun to consider and adjust aspects of their professional practice in relation to the realities and demands of cultural diversity. The health services are not an exception. In response to reported problems and observations, a growing number of New Zealand studies have identified recurring difficulties experienced by immigrant patients, especially but not exclusively people from the Pacific (e.g. Ma'ia'i, 1994; Tamasese et al., 1997; Loto-Su'a, 1996; Young, 1997; Davis et al., 1997) and refugees (e.g. North, 1995; Ministry of Health, 2001). Influenced perhaps by what Bhopal (2006: 58) perceives as a "human tendency to be interested in difference and the scientific approach to difference as the starting point for research", the great majority of the studies conducted by health

researchers during the 1990s (see Trlin and Barnard, 1997; Trlin, 2005) generally focused more upon the needs and difficulties of the new settlers (e.g. Abbott et al., 2000; Young, 1997) rather than the health professionals and the services in which they are engaged. The present study was therefore conducted to identify the impact that the immigrant population, increasing in size and diversity, is having on the delivery of primary health care services in New Zealand, and to highlight the implications for resourcing effective service delivery and the training and continuing development of health professionals with respect to cross-cultural communication and health care.

## **Immigration and Ethnic Diversity**

Since the early 1980s the world has experienced international migration and refugee movement on a scale not seen since post-World War II. As noted above, New Zealand has not been exempt from these movements with official statistics regularly providing evidence of high levels of international migration. Throughout the 1990s and the beginning of the new millennium fluctuations have been experienced in external migration, producing both gains and losses in net long-term migration (i.e. involving people who intend to change their country of residence for 12 months or more). Analysis of available official statistics suggests that while some variation has occurred in the annual number of overseas-born arrivals in response to immigration policy changes and the 1997 Asian economic crisis (see Ho and Bedford, 1998) a key factor in the pattern of gains and losses has been changes in the movement of New Zealand citizens (see Bedford and Lidgard, 1997; Bedford et al., 2005).

As one outcome of these changes in international migration, New Zealand's population has become increasingly diverse. In 2001 almost 19 percent of all New Zealand residents were overseas-born. The dominant ethnic origin group was still 'European' (74 percent of the population), followed by Maori (14 percent), Asian (6 percent) and Pacific peoples (6 percent). Though still very much a minority, New Zealand's Asian population increased by 36.8 percent during the intercensal period 1996-2001 due to both immigration and natural increase (Statistics New Zealand, 2003). That said, it is important to remember that the United Kingdom and Ireland continue to be a major source of immigrants, accounting for 32.2 percent of New Zealand's overseas-born in 2001, while immigrants from the Pacific (16.9 percent) and Australia (8 percent) together accounted for another quarter of the overseas-born (Statistics New Zealand, 2003).

The Auckland and Wellington Regions (predominantly consisting of the greater Auckland and greater Wellington urban areas, respectively) are the dominant places of settlement for new immigrants. Roughly half of New Zealand's immigrant population resides in the Auckland Region, along with 65 percent of the country's Asian population and about 66 percent of its Pacific Island peoples. Beyond

Auckland, the two largest concentrations of immigrants are in the Wellington and Canterbury Regions, which account for 12.4 and almost 10 percent of the overseas-born, respectively (Statistics New Zealand, 2003). Obviously the concentration of immigrants from diverse origins in the Auckland and Wellington Regions places heavy and in some respects unique demands upon the health infrastructure of these two areas.

## **Recent Research: A Selective Review**

As note above, although New Zealand research on aspects of immigration and health has increased since the early 1990s, the focus of most researchers has tended to be on the health needs of immigrants (particularly Asian and Pacific Island ethnic groups) and refugees. Fortunately, in some instances attention has also been directed to the views of health professionals. To provide some preliminary insights and background for the present survey, key findings from four studies by Walker et al. (1998), Holt et al. (2001), Ngai et al. (2001) and the Asian Public Health Project Team (2003) are concisely reviewed below. All four studies have a common concern with regard to the Asian immigrant/ethnic population, particularly in the Auckland region. It should be noted that members of this population (which has grown rapidly with the arrival of large numbers of well educated, skilled migrants, business migrants and entrepreneurs) have often experienced social and economic difficulties in the process of settlement (see, for example, Abbott et al., 2000; Aye and Guerin, 2001; Boyer, 1996; Henderson et al., 2001; Ho and Lidgard, 1997; Ip and Friesen, 2001; North et al., 1999). The review concludes with a brief comment on the difficulties, health needs and health service impact of refugees.

Holt et al. (2001) highlighted information and communication barriers to the use of health care services. Interviews with non-English speaking immigrants (excluding European and Pacific peoples) found a low level of knowledge of medical emergency procedures, with 42 percent unsure of the correct method for seeking medical help. This finding was consistent with an earlier finding (Walker et al., 1998) that only 49 percent of Asian immigrants had a high degree of confidence in dealing with emergency medical situations. Interviews carried out with Asian immigrants in the Auckland region also established that: about 80 percent had a regular GP, but common reasons for not seeing a GP when sick included language barriers; and about 20 percent used their traditional medicine (varying by region of origin), which was also a major reason for not seeing a Western doctor (Walker et al., 1998). The survey by Ngai et al. (2001) of Asian immigrants throughout the Waitakere and North Shore urban areas of Auckland produced similar findings, but found that their usage of GP services was comparable to that of the general population.

The immigrant populations studied by Walker et al. (1998), The Asian Public Health Project Team (2003) and Holt et al. (2001) identified the need for more affordable health services and fewer delays as areas where the health system needed to be improved. These were concerns the immigrants shared with the general population. In addition, respondents identified the need for more interpreter services and doctors from a wider range of backgrounds in order to make services more accessible. Over half of the immigrants surveyed by Holt et al. (2001) reported that if they were seriously ill they would have difficulty understanding the medical professionals' speaking of English. A better understanding of immigrants' cultures was also deemed to be necessary, a point made by the Asian Public Health Project Team (2003: 68) as follows:

*Different Asian ethnic groups have different values and beliefs. Traditional medicine and practices are often lost and not acknowledged by Western medicine. Further, the notion of culture extends beyond language difference and emphasises differences in lifestyle and health care priorities.*

The incorporation of health professionals' views, predominantly those of GPs, was evident in all four of the studies. Language was not only a barrier for immigrant patients accessing health services, but for health professionals as well as they tried to provide adequate services. According to Ngai et al. (2001), 96 percent of their respondents cited language as a barrier to providing health services for Asian patients. The latter were also identified by health professionals as having difficulty understanding the health system and being unsure of procedures such as making an appointment to see a GP.

To sum up, a number of recommendations have been made by health professionals and Asian immigrants in order to improve health services and to better meet the needs of Asians. These recommendations included (Walker et al., 1998; Holt et al., 2001; Ngai et al., 2001):

- more doctors of different ethnicities;
- more community and hospital interpreters;
- more pamphlets in other languages, particularly on the New Zealand health system; and
- more education surrounding preventative services.

Refugees, especially when compared with the well educated and skilled voluntary migrants sought by New Zealand since the late 1980s, are known to have their own distinct needs and difficulties. Having been exposed to often acute pre-migration physical and emotional stress, they are typically more at risk with respect to mental and physical ill-health as demonstrated in studies of Cambodian (Cheung, 1993; North, 1995) and Bosnian (Madjar, 2000) refugees. Their post-migration resettlement



difficulties, including health needs and accessing appropriate health services, may be exacerbated by a range of additional factors such as: language and literacy; pre-migration experiences and expectations of health services; culturally embedded beliefs, values and practices; and having to negotiate an unfamiliar – if not radically different – health system (see North, 1996; Bihi, 1999; Kambaran, 2000; Bond, 2001). Another factor that directly affects the impact of refugees upon health services, especially in the mental health domain, should also be acknowledged. This factor, noted in Sim's (2001) study of refugee needs and how they are met in Manukau City (south Auckland), concerns the selection criteria or resettlement priorities that a country applies to its admission of refugees. While some countries have been known to seek and admit the 'least difficult' cases, New Zealand has been willing to accept the 'more difficult' cases such as "women-at-risk" (who have often experienced rape, torture and severe losses), the aged and those without the support of other family members.

## **Conclusion**

Major changes in immigration policy have facilitated increased levels of immigration from non-traditional countries of origin. These changes, coupled with a continuing humanitarian commitment to refugee resettlement, have resulted in the rapid growth of a culturally diverse population, particularly in the urban areas of the Auckland and Wellington Regions. Demographic changes of this type invariably place demands upon and test the capabilities of public and private services, including health services. A growing body of New Zealand research has shown that the difficulties experienced by immigrants and refugees in using health services arise from a range of pre- and post-migration factors that are reflected in communication barriers and their unfamiliarity with the nature and procedures of the health system. Health professionals seeking to meet the needs of immigrant patients also grapple with problems, most of which are encompassed by their lack of knowledge, skills and support services for cross-cultural communication and health care.

## METHODOLOGY

---

Building on previous research this study examines the perceived impact of immigrants on primary health services in the greater Auckland and Wellington urban areas. While previous studies have tended to highlight the perspectives of general practitioners (GPs) alone, the present study also embraces the perspectives and experiences of other primary health services and their health care providers (i.e. Plunket Society nursing services for new mothers and their infants, and both public and private emergency services).

The specific aims of the study were:

- to describe the impact(s) of the immigrant population, increasing in size and diversity, on primary health services;
- to describe patterns of primary health care service use and demand associated with immigrant patients.;
- to identify the language and cultural limitations or difficulties experienced by primary health care services providing care to immigrant patients; and
- to identify the resources currently available and needed to effectively provide care for immigrant patients, and the implications for the training and continuing education of health care professionals.

### Study Design

Ethical approval for this study was gained from the Massey University Human Ethics Committee and the Plunket Society's ethics committee. Informed participant consent was gained via the Information Sheet with the participant completing and returning the postal questionnaire (see Appendix 1).

The questionnaire was posted to primary health services in the greater Auckland and Wellington urban areas, the location of the two largest concentrations of immigrants in New Zealand. For the purposes of this study, 'primary health services' were defined for potential respondents as "first contact and primary level services, including public hospital emergency services" (see Appendix 1). With the exception of Plunket Society clinics, the mailing list of these primary health care services was compiled using the 2002 *White Pages* telephone book. In the case of Plunket services, the survey Information Sheet and questionnaire was distributed to branch clinics by the Plunket Society.

The questionnaire was divided into five sections (see Appendix 2):

Section A: General information about your service

Section B: Language and communication

Section C: Cultural differences affecting expectations and demands

Section D: Support and assistance available

Section E: Optional comments

A number of factors influenced the design of the questionnaire, the most important of which was the well known problem of low response rates for mail questionnaires, particularly in the case of general practices which tend to be over-surveyed. It was therefore necessary to develop a relatively short (20 minute) questionnaire that would be immediately relevant to the intended recipients. Accordingly, the questionnaire was structured with multiple-choice answers and a minimal number of short answer questions addressing issues identified in the literature on service delivery to immigrant populations. The final (optional) section of the questionnaire provided respondents with an opportunity to discuss some specific health needs affecting immigrant populations. No questions were included that would require respondents to access patient records and databases (e.g. statistical information regarding immigrant status, place of birth, etc.). Rather, the study focused on the impact of patients who were *perceived to be “recent immigrants”*, and the nature of that impact upon the service and health professionals concerned. Nor were respondents asked to distinguish between or to consider separate categories of immigrants (e.g. skilled or unskilled, and refugees) or their particular attributes such as English language skills or prior exposure to Western medical systems. To sum up, quick and easy completion of the questionnaire was the guiding rule of thumb applied.

The concept “recent immigrants” can be problematic when not verified and is open to various interpretations. For example, while recent arrivals from Australia or the United Kingdom may not be perceived as “recent immigrants”, some New Zealand-born Asians or Pacific Islanders might well be, particularly if their preferred language is not English. A key factor underlying such perceptions may be the role of the media and/or politicians in ‘problematising’ certain physically or culturally identifiable groups. This was certainly the case in New Zealand during the 1990s (see Spoonley and Trlin, 2004). With this in mind, the term “recent immigrants” was defined for respondents as “those persons born outside of New Zealand who have settled here approximately within the last 10-20 years” and included “voluntary migrants, skilled and unskilled, and refugees” (see Appendix 1).

The questionnaire was piloted with a cross-section of health professionals, including nurses and general practitioners (GPs), and modified according to comments made. A total of 411 questionnaires were sent out to general practices, emergency medical services and Plunket services in the greater Auckland and Wellington urban areas in early July 2002 with a request that they be returned by 9 August 2002. A follow-up questionnaire was sent to general practices, private accident and emergency services, and public hospital emergency departments that did not respond to the first questionnaire within three weeks.

**Table 1: Survey response rates by respondent location and type of primary health service**

	No. Received	No. Sent*	Response Rate (%)
<b>Auckland</b>			
General Practices	75	174	43.1
Emergency Medical Services	16	24	66.7
Plunket Services	54	122	44.3
Total	145	320	45.3
<b>Wellington</b>			
General Practices	26	38	68.4
Emergency Medical Services	1	4	25.0
Plunket Services	31	49	63.3
Total	58	91	63.7
<b>Other**</b>	2		
<b>Total</b>	205	411	49.9

\* 'Number Sent' refers to the total number of health services to which the questionnaire was distributed.

\*\*Two questionnaires which were not able to be traced by location.

## Response Rates

Completed questionnaires were returned by 205 of the 411 potential respondents, yielding an overall response rate of 49.9 percent (Table 1). General practices and Plunket services were the two dominant groups among the respondents, respectively accounting for 49.3 and 41.5 percent of all of the returned questionnaires (Table 1). With private and public accident and emergency services accounting for only a small number of all responses (about 8.3 percent), they have been combined to form a single 'emergency medical services' category for the purposes of data analysis. However, additional qualitative data will distinguish between public and private services in this category where appropriate. Finally, although the great majority of identified primary health services to which questionnaires were sent (77.8 percent) and from which responses were received (70.7 percent) were located in Auckland, the response rates for both general practices and Plunket services were considerably higher in Wellington (see Table 1), which is therefore slightly over-represented among respondents in this report. We have no firm evidence to support an explanation for the variation in response rates, but suspect that Auckland's lower rates might have arisen from factors such as heavier workloads, greater sensitivity or

caution with regard to matters of immigration and perhaps greater demands from researchers than in other New Zealand centres.

## **Respondent Description**

Respondents were asked to describe their role/position in the health service where they were employed. Overall, 61 percent were nurses, 36 percent described themselves as doctors and only 3 percent stated another role/position that included jobs such as a “community health worker” and “clinical administrator”. This pattern, at least in part, undoubtedly reflects the dominance of nurses in New Zealand’s health care system (at the turn of the millennium there were about 3,200 GPs and 3,200 nurses working in primary health care, with at least as many more nurses employed in areas such as midwifery, district health nursing and sexual health). However, their dominance of the respondent role/position profile would be enhanced by the inclusion of Plunket Society services in the survey. Another possible factor concerns the influence of the Information Sheet sent to general practices and emergency services. This sheet, addressed to “The Senior Clinician”, carried as its letterhead point of origin “Nursing Division, Faculty of Medical and Health Science, The University of Auckland”. Correctly identifying the location of the principal investigator (North), it may have encouraged some recipients to pass the questionnaire to a senior nurse clinician for completion. Whatever the explanation, we have no reason to believe that the preponderance of nurses among the respondents had any adverse affect upon the quality or validity of the data collected.

# SURVEY RESULTS

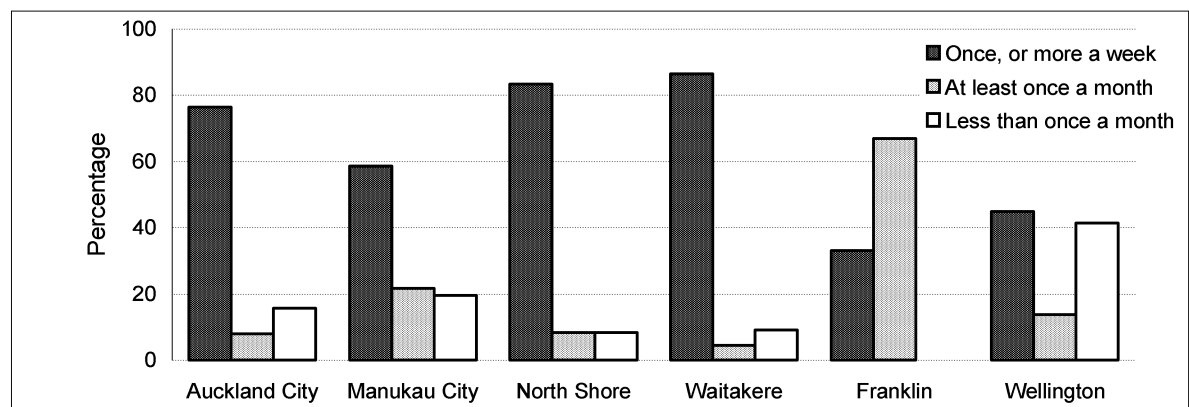
For ease of presentation, the survey findings have been organised under six main headings:

- Perceived service use by immigrants
- Perception of immigrant patients
- Perceptions of immigrant demands on services
- Impact of language, communication and culture
- Health professional preparation
- Resourcing service providers for work with immigrants

## Perceived Service Use by Immigrants

To provide rudimentary measures of service use and the prevalence of immigrant service users, respondents were asked to indicate: (a) if patients that they believed to be recent immigrants used their service; and (b) how often such immigrants appeared among the service’s patients (Appendix 2, questions A3, A4). In response to the first question, 65 percent reported that “many” used their service, 23 percent replied “several” and 9 percent indicated “a few”. Only 1 percent reported no recent immigrants among their patients, while the remaining 2 percent didn’t know. For the second question, the great majority (over 60 percent) reported the presence of recent immigrants among the service’s patients at least once a week.

**Figure 1: Frequency with which persons perceived to be recent immigrants appear among a service’s patients by urban area**



As shown in Figure 1, however, the frequency with which recent immigrants appeared among a service’s patients varied from one urban location to another.

Overall, the frequency was lower in Wellington than in Auckland, but within the latter the perceived frequency varied from one urban area to another. It was highest in the Waitakere (west Auckland) and North Shore urban areas, somewhat lower in Auckland City and especially Manukau, and lowest in Franklin (a partially rural region on the southern outskirts of Auckland) – a pattern that reflects (with the obvious exception of Pacific peoples in Manukau City) the residential location and concentration of recent immigrants in the greater Auckland urban area.

The most commonly represented origins among patients perceived to be recent immigrants presenting at the respondent's health service (Appendix 2, question A3[ii]) were: Asia (48 percent, divided between East Asia e.g. China and Taiwan with 34 percent, and South Asia e.g. India, Pakistan and Sri Lanka with 14 percent); the Pacific Islands (18 percent); and the traditional sources of Australia, North America, Great Britain and Europe (21 percent). 'Other' regions, that included Africa, South America and the Middle East, accounted for the remaining origins. A comparative analysis of these perceived origins established that Asian patients were predominant among those identified by respondents in Wellington while those from the Pacific were clearly dominant in the greater Auckland urban area, a pattern that accurately reflects the national residential distribution and concentration of Pacific migrants and their descendants. These two origin groups were also the most commonly perceived by respondents among recent immigrant patients for all three primary health service types (i.e. general practices, emergency medical services and Plunket). However, it must be emphasised that these results reflect *respondents' perceptions of recent immigrant service users*, not necessarily the *actual service use by all immigrants* (that would include those 'less visible' recent settlers from traditional source countries who escape immediate attention).

There were, however, some variations between the main origin groups in their perceived use of different health services. Such variations, which undoubtedly pose challenges of language, communication and culture to the services concerned, may be attributed to a variety of factors. For example, in the case of Plunket, where 52 percent of respondents perceived Pacific Islanders as the most commonly seen immigrant patients (compared with 15 and 23 percent for South and East Asians, respectively), the underlying factor is probably the higher fertility rate of New Zealand's Pacific Island population (see Cook et al., 2001). On the other hand, pre-migration norms and patterns of access to primary health services may explain why Asians were perceived as the most common patients for private accident and emergency services while immigrants from the Middle East and Africa were noted as prominent users of public emergency services. The use of a specific general practitioner as the first point of contact appears to be a new procedure for many recent immigrants. As one respondent (a Plunket Nurse) commented:

*Many/most new mothers are quite ignorant of the health system in New Zealand. Many from China believe that if there is a problem with baby, they should go to the public hospital as first call. But many do not know of Auckland Hospital and the Childrens' Starship Hospital...*

Indeed, ignorance of the New Zealand health system and a lack of awareness of Plunket in particular, probably explains why higher proportions of respondents from emergency services and general practices (75 and 70 percent, respectively) reported seeing recent immigrants among their patients more often (i.e. once or more a week) than Plunket service respondents (50 percent). The impact of this lack of awareness was clearly noted in comments from two Plunket Nurses in Auckland:

*Many immigrants do not understand the services we offer and we spend considerable time trying to contact them.*

*They don't know what Plunket stands for, i.e. the word has no definitive meaning to anyone outside New Zealand.*

Finally, the respondents were also asked to indicate the extent to which the main population of recent immigrant patients they encountered (as per question A3[ii]) made use of their specific primary health service (Appendix 2, question C16). At issue here were the contentious matters of cultural difference and the perceived over- or under-use of a service as compared with other patients. Quite correctly, a number of respondents pointed out that immigrant patients do not comprise a homogeneous group, with differences in both group and individual characteristics and needs influencing the ease of interaction with a health professional and presumably their use of a particular health service. For example, a GP wrote:

*You can't lump all immigrants as the same. There are differences between different cultures. But equally there is a great variation between members of different cultures e.g. a [named ethnicity] family with tertiary qualifications I find easier to relate to than some [named ethnicity] families who have very good English...*

With the above in mind, coupled with a lack of service awareness among some immigrants and/or their poor knowledge of the health system, some aspects of the results presented in Figure 2 warrant a degree of caution in their interpretation.

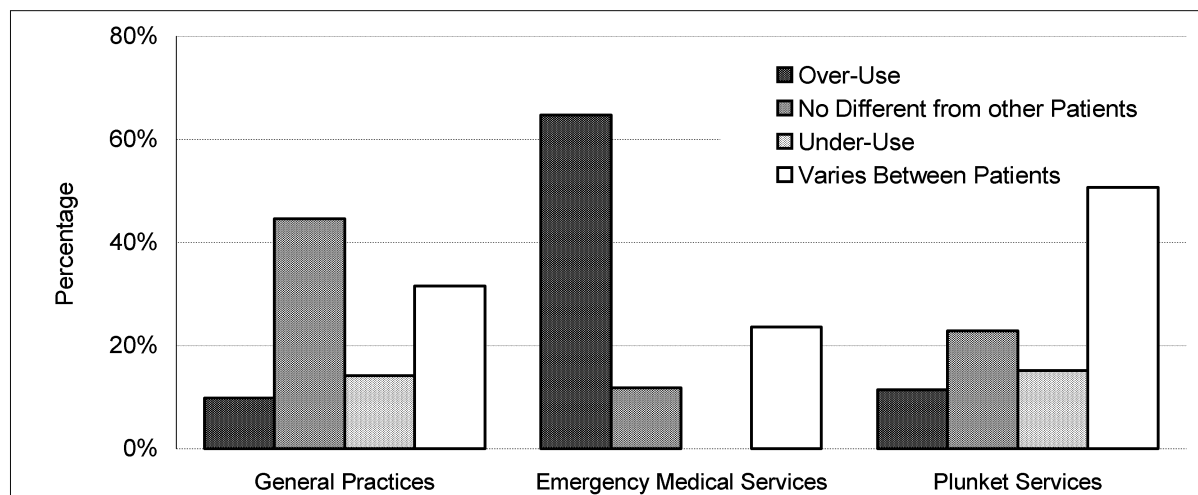
The most striking feature of Figure 2 is the high proportion of respondents who indicated that their emergency medical service was over-used by recent immigrants (65 percent, compared with less than 15 percent for general practice and Plunket services). Confirming the higher perceived prevalence of recent immigrants among emergency medical service patients (see above), this feature is enhanced by the



complete absence of any respondents who felt that this service was under-used (compared with 17-18 percent for general practice and Plunket services). Two other items of interest in Figure 2 are: (a) that almost half of the Plunket respondents felt that use of their service varied between patients, as did about one-third of the general practice respondents; and (b) that 45 percent of those involved in general practice (cf. around 20 percent or less for Plunket and emergency services) saw use of their service by immigrant patients as being no different from that of other patients. While the latter finding is somewhat reassuring, the same cannot be said of the percentages indicating that service use varied between patients. Such variation may reflect the influence of factors that affect not only the perceptions of respondents but also the behaviour of immigrant patients. Hence the need for caution as noted above, especially given a comment made by a GP in Manukau City:

*A significant number of immigrants continue to import their medication from their own country and avoid coming to their GPs for assessment and follow up of chronic or acute conditions. They only attend when they don't get better or get worse with self-medication.*

**Figure 2: Perceived use of primary health services by recent immigrants**



## Perception of Immigrant Patients

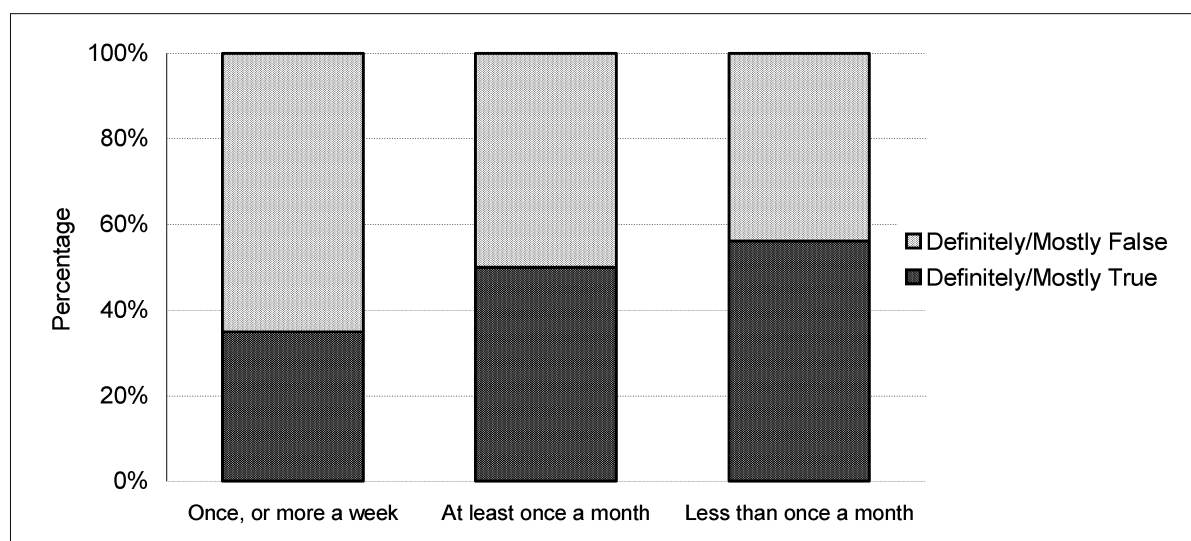
The respondents were split on whether immigrants differed from other patients. In answer to the statement “Immigrant patients are no different from any other patient” (question A5[i]), less than half agreed that they were “definitely” or “mostly” no different, while 58 percent felt the statement was “mostly” or “definitely” false. It appeared also that this perception of difference was associated to some degree with

the frequency with which immigrants were seen among a service's patients (question A4). As shown in Figure 3, about two-thirds of those who saw immigrants among their patients "once or more a week" believed that they were "mostly" or "definitely" different from other patients, as compared with little more than 40 percent of those who encountered immigrants less than once per month. Some of the possible reasons for the views expressed can be discerned in the following comments from two GPs:

*For the average immigrant their needs are identical to New Zealanders. Where there is a combination of low educational status and poor English, this presents greatest difficulties.*

*I find [named ethnicity] people the most difficult (challenging). Their symptoms are totally different to the ones I usually hear and it is difficult to associate them with anything. I often think they are post-traumatic stress related but I'm not sure.*

**Figure 3: Agreement/disagreement with the statement "Immigrant patients are no different from any other patient" by frequency with which immigrants are perceived among service patients**



The issue of difference was also taken up with respondents via a series of statements (question C17[ii-ix]) to determine their perception of the attitudes, expectations and behaviour of immigrants with regard to aspects of the health system. In general, it appears (see Table 2) that the majority of respondents who had formed an opinion saw the immigrants they encountered, compared with "other patients", as (a) not expecting admission to hospital, and (b) not being less likely to accept a practitioner's reassurances, to expect a prescription or the use of high-tech interventions (though

responses to the three latter items do not rule out the possibility that immigrants expect more than “other patients”). Furthermore, the majority of respondents with an opinion did not think that immigrant patients were “higher users of preventive care”, “frustrated that they [could not] go directly to a specialist” or that they were given to complaining “about the cost of primary health care”. On the other hand, it does seem that opinion was divided on the matter of immigrant “frustration at waiting lists”, and that a substantial minority of the respondents (27-33 percent) saw immigrants as being dissatisfied with practitioner reassurances, the cost of health care and the procedure of referral for specialist services. This belief is supported by Auckland studies where immigrants have identified the need for a more efficient health system, more affordable health services and less delay to see a doctor or specialist (Holt et al., 2001; Walker et al., 1998).

**Table 2: Respondent perceptions of immigrant patients encountered in their health service (percentages)**

Statements: <i>“Immigrant patients...</i>	Responses (%)		
	Definitely or Mostly true	Definitely or Mostly false	Don’t know
<i>...are less likely than other patients to believe your reassurances when there is nothing wrong”</i>	33	49	18
<i>...complain about the cost of primary health care”</i>	33	47	20
<i>...are frustrated that they can’t go directly to a specialist”</i>	27	42	31
<i>...are higher users of preventive care”</i>	14	56	30
<i>...are more likely than other patients to expect admission to hospital”</i>	17	47	36
<i>...express frustration at waiting lists”</i>	32	35	33
<i>...are less likely to expect a prescription than other patients”</i>	8	62	30
<i>...are less likely to expect high-tech interventions than other patients”</i>	27	48	25

An important feature of Table 2 that warrants attention at this point is the percentage of respondents who answered “don’t know”. In part this can be explained by the inclusion of Plunket Nurses whose practice is limited to infant and post-natal maternal care. They are therefore less likely to discuss with or to have experience-based knowledge of the opinion(s) of immigrant patients with regard to issues such as hospital admission or waiting lists. For example, almost 64 percent of Plunket Nurses replied “don’t know” to the statement “Immigrant patients are more

likely...to expect admission to hospital”, as compared with 17-18 percent of general practice and emergency medical service respondents. Similarly, emergency medical service respondents predominantly said they did not know if immigrants were higher users of preventive care. That said, given that there was no association between responses to the statements and the prevalence of immigrants among their patients, it seems that to some degree there was a lack of awareness or knowledge among the respondents on the outlook and/or expectations of immigrant patients.

Whether or not immigrant patients were believed to be different to others, however, all but 4 percent of the respondents agreed (45 percent “definitely true”, 51 percent “mostly true”) with the statement (question A5[ii]) “I find working with immigrant patients interesting”. For example, one GP commented:

*We have all found the increasing diversity in our local population to be positive and stimulating and above all an interesting and educational area of our work.*

This is not to say that working with them was free of frustrations. In fact, more than a quarter of the respondents agreed (5 percent “definitely true”, 22 percent “mostly true”) that they found “...working with immigrant patients frustrating” (question A5[iv]). As might be expected, the sources of this frustration (implied in some of the responses presented in Table 2 above) included those of communication with non-English speaking immigrants and the sometimes excessive or unnecessary demands they made, as illustrated by a nurse and a GP, respectively:

*Whilst I accept that non-English speaking recent migrants [may have trouble communicating] – I find it frustrating at times that particularly [named ethnicity] of 10 plus years New Zealand residency, can ‘feign’ incomprehension as they do.*

*Our [named ethnicity] patients are very patient and don’t like to complain; may present late and have many health problems...[on the other hand] our [named ethnicity] patients [are] often not very unwell but want every test and specialist (and want it all for free), quite demanding.*

## **Perceptions of Immigrant Demands on Services**

Almost all respondents rejected a statement claiming that “Less time is needed with immigrant patients than with other patients” (question A5[iii]); 69 percent found it “definitely false” and 23 percent “mostly false”. As might be expected, the strength of this rejection varied according to (a) the type of primary health service, and (b) the prevalence of immigrants among a service’s patients. To be more specific, while the statement was *unanimously* rejected by only emergency service respondents, the

“definitely false” view was far stronger among Plunket respondents (82 percent) than among those in either general practice (60 percent) or emergency services (59 percent). Similarly, a positive relationship was found between the perceived prevalence of immigrant patients and the strength of the respondents’ views. Among those with (at most) only “a few” immigrants perceived among their patients, 47 percent believed that the statement was “definitely false” as compared with 67 and 74 percent of the respondents in services with “several” and “many” perceived immigrant patients, respectively.

Numerous additional comments were made on this issue, and of these (three of which are quoted below) some identified reasons for the time consuming nature of work with immigrants:

*More home visiting takes place as mothers are isolated and don’t come to clinics without their husbands. Many won’t consider walking to the clinic so continual home visiting is required which puts more pressure on the nurse’s workload (Plunket Nurse, Auckland).*

*A lot more time is required from the medical and nursing staff to explain treatment, follow up hospital clinics etc...on the positive side [a] sensible attitude to ageing and willingness to care for elderly or chronically ill within the family at home, relieves pressure on the health service... (GP, Auckland).*

*Additional time is required for immigrant visits – especially if translation is required (GP, North Shore).*

To assess the perceived future (rather than the current) impact of immigrants on service delivery, respondents were asked (question D21) “To what extent do you believe [that] increased immigration will put pressure on health care services such as yours?” Only 8 percent anticipated “no pressure at all”, 27 percent indicated “some pressure, but we can manage”, while the majority (55 percent) believed there would be “considerable pressure, but we will manage with support” and the remaining 10 percent answered “enormous pressure, we can’t cope”. As shown in Figure 4, Plunket and (to a lesser degree) emergency medical service respondents were those who believed the pressure would be greatest.

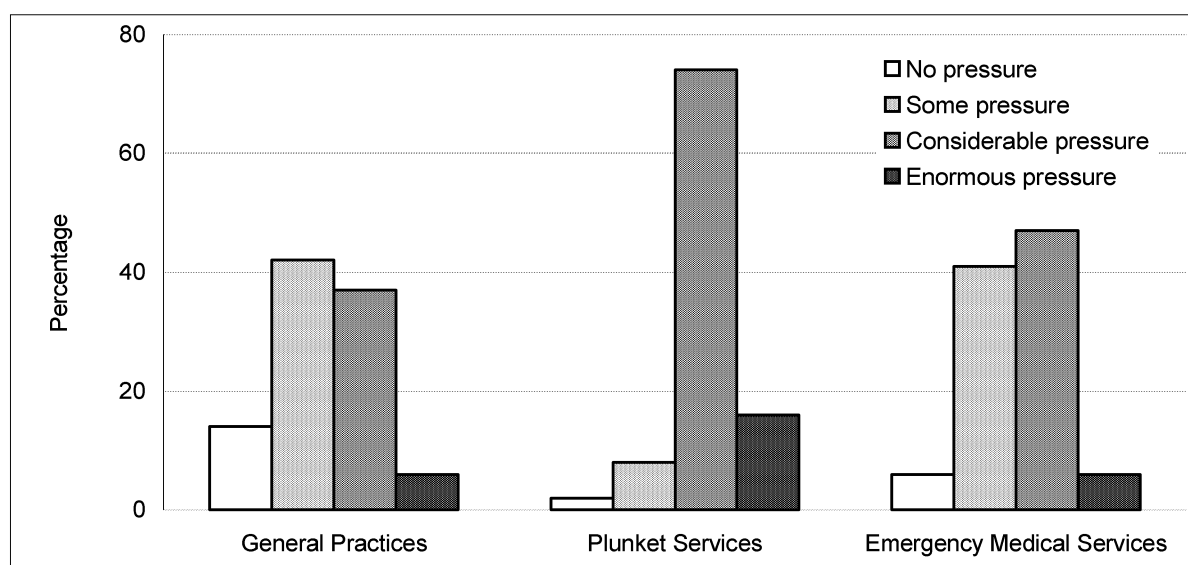
Perhaps the views of Plunket Nurses reflect Plunket’s status as a non-profit organisation with services only partly covered by government funding. That said, they and other respondents were not short of other reasons for anticipating difficulties with considerable or enormous pressure from (increased) immigration.

*At least half our patients are immigrants by your definition. Immigrants tend to be poor. General practice is currently a small business. Poor people are unable to pay for high level and sophisticated services. Our business would fail if we provided such services. We do the best we can (GP, Auckland).*

*Pressure is experienced right across the full spectrum – not just health but pressure on other services e.g. housing, education - but it eventually falls back on health again. Immigrants should be actively discouraged from settling in Auckland and Wellington (Practice Nurse, North Shore).*

*Many of our patients are ‘overstayers’. They have New Zealand-born children but [the] parents are not entitled to housing or benefits so live in crowded conditions. The effects on the children’s’ health is enormously detrimental. Personal frustration for staff can be enormous too (Plunket Nurse, Waitakere).*

**Figure 4: Anticipated extent of pressure from increased immigration by type of health service**



Overall, the pattern of responses with respect to the anticipated extent of pressure from increased immigration should be heeded as a signal for both (a) further consultation with health professionals by government policy analysts, and (b) of the need for more collaboration between government ministries and departments in the development and implementation of immigration, health and other social policies.

## Impact of Language, Communication and Culture

Recognising the importance of an immigrant patient's English language ability and the health service provider's awareness of the cultural needs of different groups, the survey questionnaire included a number of statements on language, communication and cultural issues to which the participants were asked to respond.

### *Language and communication*

Table 3 provides a summary of responses to five statements (question B12) relating to language and communication with immigrant patients. The majority of respondents agreed that for "at least once a month" communication with patients who were non-English speakers or whose English was limited was "time consuming" and "stressful or frustrating". Similarly, the majority agreed that, for "at least once a month", there were "instances" with immigrants where they: believed a patient had "not followed instructions because of communication problems"; were uncertain that a patient had understood what was said; and where they themselves were "unable to understand what the... patient was saying..".

**Table 3: Responses to five statements concerning communication with immigrant patients (percentages)**

Statements: <i>"At least once a month..."</i>	Responses (%)	
	Mostly or Definitely true	Mostly or Definitely false
<i>...trying to communicate with patients who speak languages other than English/whose English is limited is time consuming."</i>	78	22
<i>...difficulties in communicating with patients who speak languages other than English/whose English is limited are stressful or frustrating."</i>	58	42
<i>...there are instances when I believe the immigrant patient has not followed instructions because of communication problems."</i>	62	38
<i>...there are instances where I am uncertain that the immigrant patient has understood what I said."</i>	74	26
<i>...there are instances when I am unable to understand what the immigrant patient was saying to me."</i>	64	36

Agreement with these statements did, of course, vary in relation to a number of factors. For example, agreement (i.e. “mostly/definitely true”) that communication was “time consuming” ranged from 43 percent among respondents reporting that there were only “a few” recent immigrants perceived among patients using their service to 71 percent among those indicating the perceived presence of “many” immigrants among their patients. Similarly, agreement that communication was “stressful or frustrating” was lower among general practice respondents (50 percent) than for those engaged in either Plunket (64 percent) or emergency medical services (76 percent). Finally, it may be noted that the experience of immigrant patients not following instructions because of communication problems varied with geographic location; the percentage agreeing with the statement was lower for Wellington respondents (47 percent) than those in Auckland, and within the greater Auckland urban area ranged from 85 percent for Waitakere City to 60 percent for Manukau City and 22 percent for the outlying Franklin district.

Additional comments, which usefully elaborated upon and/or clarified some of the language and communication issues, were made by a number of the participants in relation to their responses. Five examples of such comments are presented below:

*Many non-English speaking immigrants (especially Asian cultures) will nod and agree with everything you say when in actual fact they are not understanding you and this often gives us false information (Practice Nurse, North Shore).*

*To try and convey any health education to a client who speaks or understands no English is really frustrating to both the client and the nurse. It is difficult to elicit an adequate reply and to assess the individual needs of the client. Miming, hand signs and using other family members as interpreters is far from adequate in trying to reach our goal of achieving healthier children in the world! (Plunket Nurse, North Shore)*

*The common mode of interpretation used by immigrants is to bring a relative or associate with them to interpret. Language barriers can definitely delay accurate assessment and management in an emergency situation (Clinical Leader, Emergency Medical Service).*

*Good effective and acceptable communication is part of effective health delivery. Relatives as interpreters can sometimes be unreliable i.e. they may leave out certain phrases/concerns and vice versa (GP, Manukau City).*

*I am given many examples of how people are treated badly, treated as though they are idiots because of their skin colour and the fact they cannot speak English. Procedures are not explained and an interpreter is not on hand or asked for (Nurse, Auckland City).*



Obviously the *inability* of health professionals to accurately diagnose illnesses and of patients to comprehend instructions and to follow treatments prescribed because of language barriers may have very serious health and safety consequences. It was not surprising therefore that a Plunket Nurse in Manukau City, well known for its concentration of Pacific peoples and the use of Pacific languages (see Bell et al., 2001), should count herself “fortunate to have spent some years in Samoa” and to be able to “communicate in Samoan”. Nor was it surprising to find another Plunket Nurse in Wellington, recognising “a large group of clients...disadvantaged in most areas of health”, claiming that it was “essential to recruit staff who speak Samoan and other Pacific languages”. Similar comments could be and have been made by other health professionals in relation to the arrival and settlement of Asian immigrants. In these terms, the responses (Table 3) and additional comments reported above are disquieting, to say the least, and have far-reaching implications for the training of health professionals and the health service support resources available to them – topics which are addressed in later sections of this report.

### *Culture*

As long recognised in New Zealand’s increasingly diverse population (see Kinloch, 1985; Metge and Kinloch, 1978), an awareness of cultural differences, if not an understanding of a patient’s culture, is just as important as an ability to surmount language barriers and engage in effective communication. Failings in cultural awareness and/or understanding may appear in situations such as the inappropriate use of a male interpreter for a female patient, an inability to comprehend a patient’s health care attitudes and expectations or the ways in which patients from different cultural backgrounds make known their fears and feelings of illness and their experience of pain.

Some aspects of this topic have already been noted indirectly with respect to the perception of immigrant patients (see Table 2). Accordingly, the results presented here are limited to the participants’ responses to two statements on immigrant expressions of pain and illness (question C17[i and x]). As shown in Table 4, the majority (70 percent) of respondents agreed that immigrants “express their concerns and symptoms differently” and 51 percent agreed that immigrants “express their pain differently”. When coupled with the percentage of respondents who disagreed with each statement, and especially the percentage that replied “don’t know” for the expression of pain, these results raise questions about the knowledge and cultural awareness of health professionals that once again have implications for their training and support services.

**Table 4: Responses to two statements concerning differences between immigrants and other patients with regard to pain and illness (percentages)**

Statements: <i>"Immigrant patients...</i>	Responses (%)		
	Definitely or Mostly true	Definitely or Mostly false	Don't know
<i>...express their pain differently from other patients"</i>	51	29	20
<i>...express their concerns and symptoms differently from other patients"</i>	70	26	4

The following comment by an Auckland City GP illustrates the nature of difficulties facing some health professionals in their work with patients whose experiences, backgrounds and symptoms may be far removed from those with which they are familiar:

*I find [named ethnicity] people the most difficult (challenging). Their symptoms are totally different to the sort I usually hear, and it is difficult to associate them with anything. I often think they are post-traumatic stress related but I'm not sure.*

This GP was not alone in voicing such a difficulty. Three respondents individually commented on the difficulties they experienced diagnosing mental health problems in patients from the same ethnic group. Two of them associated these problems with post-traumatic stress, while the third believed it was a cultural issue. The simplest and most obvious conclusion to be drawn from such examples is that increasing population diversity may dramatically extend the knowledge base required by health professionals for decision-making in the diagnosis and treatment of problems presented by immigrant patients.

## **Health Professional Preparation**

The adequacy of preparation for work with (a) patients who speak languages other than English or whose English is limited, and (b) patients whose cultures are different, was tackled in the survey via a series of eight statements (questions B13 and C18). Respondents were simply asked to indicate if each statement applied to their service. The results (Table 5) clearly indicate a widespread acknowledgement of problems in the preparation of health professionals for work with immigrants, a need

for continuing education and for employer provided opportunities for professional development, as well as an apparent need for curriculum reviews in professional education. Even allowing for differences in opinion among the respondents, the results suggest an urgent need for concerted action by professional associations, tertiary educational institutions and health service employers.

**Table 5: Responses to eight statements concerning the preparation of health professionals for work with immigrant patients (percentages)**

Statements:	Responses (%)	
	Yes	No
<i><b>“How adequate do you believe is the preparation of the health professionals in your service...”</b></i>		
<i><b>...to work with [immigrant] patients who speak languages other than English/whose English is limited”</b></i>		
<i>“It does not appear to be a problem to health professionals in our service”</i>	19	81
<i>“I believe this is an area where continuing education is needed”</i>	69	31
<i>“Our employer provides opportunities to develop/improve our skills”</i>	24	76
<i>“The subject of cross-cultural communication was taught in professional education”</i>	39	61
<i><b>...to work with immigrant patients whose cultures differ from the New Zealand culture[s] you are familiar with”</b></i>		
<i>“It does not appear to be a problem to health professionals in our service”</i>	19	81
<i>“I believe this is an area where continuing education is needed”</i>	71	29
<i>“Our employer provides opportunities to develop/improve our skills”</i>	32	68
<i>“The subject of culture and cross-cultural health care was included in professional education”</i>	48	52

Many of the respondents took the opportunity to provide additional comments on this subject. The examples presented below were selected to illustrate viewpoints consistent with those of the majority, dissenting viewpoints and the fact that some health professionals (e.g. Plunket Nurses) believed themselves to be well prepared.

*I feel continuing education in languages other than English is not a priority for medical professionals. We need to be improving our medical skills not wasting our time with language. Maybe immigrants should be directed to appropriate clinics where there is a professional with the same tongue (Practice Nurse, Auckland).*

*On-going education for staff is of paramount importance. [That is] appropriate and applicable education to meet the needs of staff out in the workforce (GP, North Shore).*

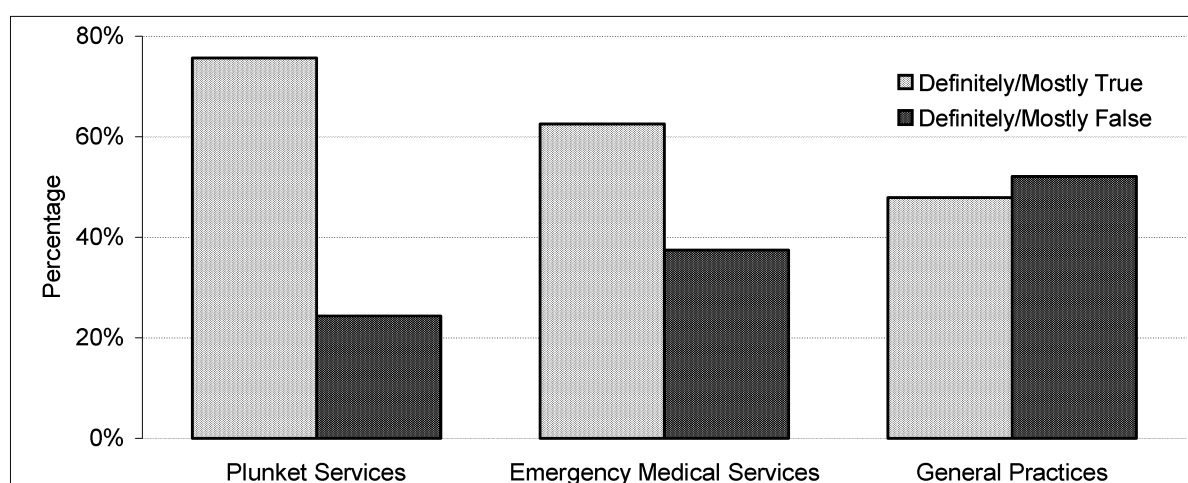
*Plunket nurses have a good basic training, seem to communicate well over a range of cultures. [Our] on-going training in cultural awareness and sensitivity helps (Plunket Nurse, Auckland).*

*Plunket provides a lot of information on Pacific and Maori health. We need to be more informed about other cultures (Clinical Leader, Auckland).*

## Resourcing Service Providers for Work with Immigrants

Given the strains, difficulties and concerns identified above, our focus here is on the extent to which service providers feel that they are adequately resourced for work with immigrants, and the areas in which additional support is or will be needed.

**Figure 5: Agreement by service type with the statement "Health services like this one are not adequately resourced to meet the demands of immigrant patients"**



An early indication of dissatisfaction was provided in responses to the statement "Health services like this one are not adequately resourced to meet the demands of immigrant patients" (question A5[v]). Overall, 29 and 32 percent believed the statement to be "definitely" or "mostly" true, respectively. Furthermore, a higher level of agreement was found among Plunket and emergency medical service respondents than those in general practice (Figure 5). Unlike GPs, who charge or claim a fee for service, both Plunket and public (but not private) emergency services have capped budgets to deliver services on demand. As one Plunket Nurse put it:

*There are many challenges to break down barriers in relation to culture in order to build a positive trusting relationship with clients – so that primary health needs*

*can be addressed. The government and Ministry of Health need to understand that this entails additional resources, and [to] fund appropriately for this.*

### ***Immigrant staffing***

A valuable resource for services working with immigrant patients is the presence of immigrant staff. Such staff are (or are assumed to be) well equipped (a) to directly provide for, and/or (b) to communicate with and interpret for members of their own ethnic group, and (c) to educate or train other staff to deliver culturally appropriate care. To gauge the presence of this resource, therefore, survey participants were asked if any of their business partners, colleagues or other service staff were recent immigrants (question A6). More than half (55.5 percent) replied in the affirmative but the percentage varied by service type, ranging from 81 percent for emergency services to 60 and 48 percent for Plunket and general practice services, respectively. It must be noted, however, that both of the latter services are likely to be small in size and therefore employ fewer staff than emergency services. The most common origins of immigrant staff were the Pacific (33 percent), Asia (21 percent) and South Africa (16 percent), with only 18 percent known or perceived to be from traditional source countries (UK etc.).

Two main positions/roles (question A7) were taken up by immigrant staff – as nurses (40 percent) and doctors (24 percent) – with the remainder in a residual category (36 percent) reflecting their employment in non-traditional health roles (such as Plunket “community workers”) and administration (e.g. as receptionists). The respondents were very supportive of the employment of immigrant staff – especially those with specific language skills – as indicated in the following comments:

*The fact that we have multi-cultural staff must help some immigrant patients feel at ease* (Practice Nurse, North Shore)

*Due to the service we deliver I believe that...you use your immediate staff to bridge language barriers, or access family members as interpreters to convey information to those who have no understanding of English. Our community contains a large population of Pacific Islanders and others so our service needs and has set in place staff to deliver to our clientele* (Practice Nurse, Manukau City)

*Chinese clients with little English are referred to the Chinese nurses as are Pacific Island clients* (Plunket Nurse, Auckland City)

It was anticipated that immigrant staff would assist in communicating with non-English speaking patients (question A9[i]), however the prevalence of this practice was higher than anticipated. Reported by 77 percent of respondents in all services

employing immigrants, the percentage was higher for Plunket (88 percent) than for either general practice (71 percent) or emergency services (72 percent). Samoan was the language in which staff were reported to most commonly communicate with patients (20 percent) followed by Cantonese (16 percent) and Mandarin (15 percent). The obvious value of immigrant staff may, of course, be recognised and exploited not just by colleagues and other service personnel but by members of their own ethnic group, a situation that exposes them to excessive demands and pressures. Too often overlooked, this point was recognised by a Plunket Nurse in Waitakere who commented:

*I believe my work colleagues who are immigrants experience the most pressure as their own people have enormous expectations of them. They are the ones who require a lot of support.*

### ***Language provision for non-English speaking patients***

In addition to the resource represented by immigrant staff members, the issue of language and communication resources was tackled via questions concerning: (a) the provision of “written health information and pamphlets in languages other than English” (question B10); and (b) the use, nature and cost of interpreter services (question B11). The need for such questions was signalled in the findings of some recent Auckland studies (Asian Public Health Project Team, 2003; Holt et al., 2001; Ngai et al., 2001) which indicated that language provisions were not meeting the needs of immigrant patients.

**Table 6: Provision of written materials in languages other than English by perceived prevalence of recent immigrants using a primary health service**

Provision of written materials in languages other than English	Perceived prevalence of recent immigrants using a service							
	None		A Few		Several		Many	
	No.	%	No.	%	No.	%	No.	%
Yes	3	100	14	74	32	71	111	86
No	0	0	5	26	13	29	18	14
Total	3	100	19	100	45	100	129	100

Written health information and pamphlets in languages other than English was reported by respondents to be provided by 81 percent of the health services they

represented. Table 6 shows that the provision of this material varied somewhat according to the perceived prevalence of recent immigrants among a service's patients, but it reveals also that such material was *not* being provided by a substantial percentage of those services with either "several" or "many" recent immigrants using the health service.

Gaps in the provision of written information/pamphlets in languages other than English may, at least in part, be attributed to the unavailability or limited availability of such material. As indicated in the comments that follow, this point was made by some of the respondents and it highlights an area where primary health service providers could fruitfully be supported in their work with immigrant patients.

*...the use of interpreted information is...essential – more pamphlets in different languages need to be made available as we have currently resourced our own especially Assyrian, Arabic, Somalian, Ethiopian, Cambodian (Practice Nurse, Wellington)*

*We have contacted many health services in New Zealand and found almost nil information in languages other than English/Maori/Pacific Islands. Breast screening/Cervical screening only found in Asian Languages (GP, Auckland)*

The phrase "...we have currently resourced our own..." in the first comment above is important. It indicates that this service, perhaps like others, has not been passive in the absence of written information/pamphlets in languages other than English but has responded by producing its own written material for immigrant patients. This is a commendable response, but one that probably entails considerable costs across a range of primary health services in the absence of appropriate and readily available material from the Ministry of Health and/or other organisations.

The use of interpreter services was reported by 66 percent of the respondents, 10 percent indicated that the need for an interpreter had not arisen and the remaining 24 percent had not used such services. Where interpreters were used (N=132), the service types most commonly employed (question B11[ii]) were patient-arranged interpreters (e.g. a relative or friend) and a health service staff member (Table 7). Use of a professional interpreter (personally present during a patient's appointment) was rather limited, with respondents indicating strongly in their comments that this was due to the cost involved.

Analysis of the use of each type of interpreter service by health service types revealed some interesting patterns (Table 8). For example, it was found that for all users of a particular type of interpreter service: (a) Plunket services accounted for over half of the cases where a staff member was used; whereas (b) general practices dominated

the use of a patient-arranged interpreter and accounted for more than 40 percent of the users of professional interpreter and telephone interpreter services.

**Table 7: Types of interpreter services used (N=132)**

Types of interpreter services	Use of service type			
	Yes		No	
	No.	%	No.	%
Telephone interpreter services	12	9.1	120	90.9
Professional interpreter personally present	22	16.7	110	83.3
Patient-arranged interpreter (e.g. relative, friend)	93	70.4	39	29.6
Staff member	76	57.6	56	42.4

**Table 8: Use (“Yes”) of specific interpreter services by respondent’s health service type (percentages)**

Types of interpreter services	Primary health service type		
	General practice	Plunket service	Emergency service
Telephone interpreter services	42	33	25
Professional interpreter present	45	18	36
Patient-arranged interpreter (e.g. relative or friend)	53	34	13
Staff member	38	51	11

Comments from Plunket service respondents suggest that the use of interpreter services, especially a heavy reliance on staff, was a source of dissatisfaction that stemmed in the main from limits on funding and/or staff training:

*The Plunket Society is not looking at “the future.” According to statistics, 183,000 [immigrants], 11,500 of these being Chinese are coming to Auckland. They are not training Nurses who speak their language nor do they seem to care. Those of us that speak their language are asked to see these clients, causing greater stress and burnout (Plunket Nurse, Auckland).*

*We have a very big and ever increasing need for interpreter services in our service. However, Plunket receives 75 percent of its funding from the MoH which is clearly*



*inadequate to fund our service much less additional services such as interpreters (Plunket Nurse, Auckland).*

Plunket Nurses, of course, were not alone in expressing such feelings. Similar comments regarding costs and training, as well as the adequacy of non-professional interpreter services and the influence of ethnic community politics, were made by some of the other respondents:

*We have some basic written cards in many languages put out for clients. This assumes literacy. Cost of professional interpreters is high. Some groups are distrustful of interpreters as a result of some local problems... (Clinical Leader, Wellington).*

*The wrong languages are bought. Medical people receive no teaching in the languages or culture of the vast number of immigrants (GP, North Shore).*

*Patients cannot afford professional interpreter services – it is unclear when using a family member whether information is being communicated as I would like, or whether information is being altered to accommodate cultural issues (Charge Nurse, Auckland).*

*Older child [serving] as translator for parent; incorrect hierarchy; no privacy or boundaries around sensitive issues (GP, North Shore).*

The fact that only 15 (11.4 percent) of the 132 primary health care services using some form of interpreter service paid for the service as a budget line item (question B11[iii]) is significant. All but 1 of these 15 services were among those for which the respondents indicated the presence of “many” patients they believed to be recent immigrants (99 cases out of 132 using interpreter services). Needless to say this finding confirms the heavy reliance on informal and free interpreter services rather than paid professional services as shown in Table 7 above.

## SUMMARY AND RECOMMENDATIONS

---

Since the mid-1980s, New Zealand's population has been increasingly diversified through immigration. The arrival and concentration of large numbers of immigrants from non-traditional backgrounds (i.e. non-European and/or non-English speaking), especially in the Auckland and Wellington Regions, has posed challenges and difficulties for a broad range of public and private services, including those for health care. There have been reports and claims that primary health services have struggled to meet the needs of these immigrants, lacking the funding, suitably trained staff and other resources required for effective cross-cultural communication and health care. Accordingly, the aim of this survey was to gauge the awareness, perceptions and experiences of three groups of primary health service providers with regard to these recent immigrants, and their views with respect to the skills and training of health professionals and other resources required for work with immigrant patients.

The results presented in this report are summarised here using a question and answer framework to highlight the main areas of interest. On the basis of the key findings, the report concludes with a set of recommendations for consideration and discussion by the stakeholders involved.

### Summary

**Are primary health service providers aware of immigrants among their patients, do they feel their service is being over-used and do they anticipate pressure from increased immigration?**

The survey respondents were well aware of the presence of recent immigrants among their patients. Key findings indicating this awareness were as follows:

- 65 percent perceived “many” and a further 23 percent “several” recent immigrants among patients using their service.
- 63 percent or more perceived such patients among their service users “once or more a week”. This level of service contact was found to be more prevalent within the greater Auckland urban area (at or about 80 percent for Waitakere, North Shore and Auckland City) than in Wellington – a pattern reflecting the distribution and concentration of recent immigrants – and for emergency medical and general practice services (at or above 70 percent) than for Plunket services (50 percent).

A topic of concern in media reports and anecdotal evidence is that immigrants rely heavily on (i.e. over-use) public hospital emergency departments for health care. This reliance may indicate: that emergency services are seen as a means of gaining free

health care; and/or that many immigrants are unaware or unsure of the appropriate sources for health care when it is required (see Walker et al., 1998; Holt et al., 2001); and/or that the pre-migration patterns of health care use can have a significant impact on the utilisation of services by immigrants in their new country of settlement (see Ngai et al., 2001; Asian Project Team, 2003; Walker et al., 1998). Whatever the reason, the survey provided some support for this concern about service over-use:

- 65 percent of emergency medical service respondents believed that immigrant patients over-use their health service, compared with approximately 10 percent of both the general practice and Plunket respondents in relation to their own services.

This finding indicates the need for further research to determine the reason(s) why immigrants appear to make more use of emergency medical services (including the costs of other primary health services in relation to the incomes of different migrant groups) in order to reduce the pressure on emergency services.

Finally, there can be little doubt that the pattern of immigration since the early 1990s and the associated challenges, demands and difficulties faced by primary health services, have lead the majority of respondents to anticipate pressure from increased immigration:

- 55 percent of the participants believed that increased immigration would put “considerable pressure” on their type of service, but (crucially) felt they would “manage with support”. An additional 10 percent, however, replied that the effect would be one of “enormous pressure” with which they would be unable to cope. Plunket respondents were clear leaders in anticipating “considerable” or “enormous” pressure, followed by those in emergency services.

It should be noted that this pressure was not simply a matter of an increased workload, but embraced also the time required and the frustrations of language, communication and culture in work with immigrants from diverse backgrounds (see below). The lead position of Plunket respondents in anticipating pressure is not surprising. As a non-profit organisation, Plunket has a particular need for additional funding if its staff (often struggling to see their ‘quota’ of patients in order to meet contractual requirements) are to provide an effective service for patients from non-traditional ethnic backgrounds who require the use of interpreters, more time and more home visits.

**What were the main origins of recent immigrants encountered by primary health service providers, and were certain groups perceived to be more prominent in some areas and among the users of some types of services than others?**

When asked to identify the most common countries/regions of origin of immigrants perceived among their patients, the origins specified by respondents echoed the diversity arising from changes in immigration policy:

- 48 percent identified Asian countries/regions (34 percent East Asian, 14 percent South Asian), 21 percent traditional origins (the United Kingdom, Australia, Europe and North America), 18 percent Pacific origins, and the remaining 13 percent a number of other places in Africa, South America and the Middle East.

These origins varied somewhat by urban area and the type of service involved:

- Immigrants from Pacific origins were, as expected, clearly predominant in the Auckland area, while immigrants from both South and East Asia were more prominent among those perceived by respondents in the Wellington area.
- 52 percent of Plunket respondents identified Pacific Islanders as their most commonly seen immigrant patients, while Asians (East and South Asians combined) were the most common patients identified by 53 percent of emergency service respondents (especially for private services) along with a high representation for immigrants from the Middle East and Africa (for public services).

These variations, which no doubt pose challenges and difficulties for service staff, can probably be attributed to various factors such as fertility rates (for Pacific migrants using Plunket services) and pre-migration norms and patterns of primary health service access (for Asians and others using emergency services). However, there is still a need for further research with ethnic communities to examine and clarify their reasons (e.g. cost, traditional service access patterns, interpreter availability) for using particular services, especially emergency services as a first port of call.

### **Are recent immigrants perceived to be different to other patients and, if so, why?**

The respondents were more or less split on whether immigrants differed from other patients:

- Although 58 percent felt that the statement “Immigrant patients are no different from any other patients” was “mostly” or “definitely” false, 42 percent thought it was “definitely” or “mostly” true. This perception appeared to be associated, to a degree, with the frequency with which immigrant patients were seen; the more frequent the contact with immigrants among their patients, the greater the percentage of respondents who believed that immigrants were “mostly” or “definitely” different from other patients.

Possible reasons for accepting or rejecting the notion of ‘difference’ were initially unclear. Indeed, in relation to respondent perceptions of the attitudes, expectations and behaviour of immigrants with regard to aspects of the health system, it was found that among those who had formed an opinion:

- the majority saw immigrants, compared with “other patients”, as (a) not expecting admission to hospital, and (b) not being less likely to accept a

practitioner's reassurances, to expect a prescription or the use of high-tech interventions.

- the majority did not think that immigrant patients were "higher users of preventive care", "frustrated that they [could not] go directly to a specialist" or given to complaining "about the cost of primary health care".

On the other hand, it does seem that:

- opinion was divided on the matter of immigrant "frustration at waiting lists"; and
- a substantial minority (27-33 percent) saw immigrants as being dissatisfied with practitioner reassurances, the cost of health care and the procedure of referral for specialist services.

An important feature of respondent perceptions on these topics was the percentage answering "Don't know". In part reflecting an inability or perhaps reluctance to offer an opinion outside their field of practice or experience (most likely in the case of Plunket Nurses), it also seems to indicate a lack of awareness or knowledge among the respondents concerning the outlook and/or expectations of immigrant patients – a factor that might well contribute to a sense of 'difference'. However, more specific reasons for a perception of 'difference' emerged with respect to the difficulties posed by language, communication and culture (see below).

Whether or not they believed immigrant patients to be different, the respondents acknowledged that working with such patients was interesting and for some of them frustrating:

- 96 percent agreed (45 percent "definitely true", 51 percent "mostly true") with the statement "I find working with immigrant patients interesting"; and
- 27 percent found "working with immigrant patients frustrating" (5 percent "definitely true", 22 percent "mostly true")

**What are the main difficulties in work with immigrant patients and are such difficulties more commonly perceived or experienced by some primary health services than others?**

The main difficulties experienced in work with immigrants are well known among health service providers as being those of time, language, communication and culture. These difficulties were confirmed by the respondents. For the issue of time:

- 92 percent rejected a view that "Less time is needed with immigrant patients than with other patients" (69 percent "definitely false", 23 percent "mostly false").

The strength of this rejection varied according to primary health service type, and the perceived prevalence of immigrants among a service's patients:

- while *unanimously* rejected by only emergency service respondents, the "definitely false" view was stronger among Plunket respondents (82 percent)

than among either general practice (60 percent) or emergency service (59 percent) respondents.

- a positive relationship was found between the prevalence of immigrant patients and the strength of the respondents' views; the greater the prevalence of immigrants among patients, the more likely were respondents to believe that the statement was "definitely false".

Difficulties experienced with language/communication explain (at least in part) the problem of time, identify a source of frustration and have far-reaching implications for safe practice. Most respondents agreed (i.e. "mostly/definitely true") that:

- for "at least once a month" communication with patients who were non-English speakers or whose English was limited was "time consuming" (78 percent) and "stressful or frustrating" (58 percent); and
- for "at least once a month", there were "instances" where they: believed that a patient had "not followed instructions because of communication problems" (62 percent); were uncertain that a patient had understood what was said (74 percent); and where they themselves were "unable to understand what the... patient was saying.." (64 percent).

This agreement varied in relation to different factors. For example: agreement with the "time consuming" nature of communication was positively associated with the perceived prevalence of immigrant patients; and agreement that communication was "stressful or frustrating" was lower among general practice respondents (50 percent) than for either Plunket (64 percent) or emergency service (76 percent) respondents.

Language was not the only barrier to communication. Awareness if not an understanding of cultural differences is just as important for consultation and diagnosis. This point was recognised by most of the respondents who agreed that immigrants:

- "express their concerns and symptoms differently" (70 percent); and
- "express their pain differently" (51 percent).

However, the percentage either disagreeing or replying "don't know" to each statement (30 and 49 percent, respectively) should be treated as a matter of concern.

Overall, these findings with regard to the difficulties of language, communication and culture, consistent in some respects with the findings of other studies (e.g. Holt et al., 2001; Walker et al., 1998), obviously have: (a) the potential for serious health and safety consequences; and (b) implications for the training of health professionals and the service support resources available to them (see Pauwels, 1995).

**Are health professionals in the primary health services perceived as being well prepared for work with immigrants?**

Referring to professionals in their own service and the adequacy of preparation for work with patients (a) speaking languages other than English or with limited English, and (b) whose cultures are different, the majority of the respondents:

- rejected the *absence* of a problem (81 percent in each case);
- acknowledged the need for continuing education (69 and 71 percent, respectively);
- rejected statements claiming that the employer provided opportunities to develop or improve skills (76 and 68 percent, respectively); and
- rejected statements claiming that the subject in question was taught or included in professional education (61 and 52 percent, respectively).

Overall, even allowing for differences in opinion among the respondents (within and between different types of services), the results suggest an urgent need for concerted action by professional associations, tertiary educational institutions and health service employers.

**Are primary health services perceived to be adequately resourced for work with immigrants, and if not what types of resources are required?**

The majority of the respondents were dissatisfied with the resources available. In response to the statement “Health services like this one are *not* adequately resourced to meet the demands of immigrant patients”:

- 61 percent believed it to be “definitely” or “mostly” true, the percentage being much higher among Plunket respondents (71 percent) than those engaged in either emergency services or general practice.

Given the difficulties experienced with language and communication, resources in this area could be expected to be an obvious point of concern. In particular, it was found that:

- although the provision of written material in languages other than English was reported by 81 percent of the respondents, such material was not being provided by a substantial percentage of services with a higher perceived prevalence of immigrants (i.e. “several” or “many”) among their patients;
- although the use of interpreter services was reported by 66 percent of the respondents (10 percent indicated that the need had not arisen), the types most commonly employed were patient-arranged interpreters (70.4 percent) and a health service staff member (57.6 percent) while the use of either a professional interpreter (personally present) or a telephone service was limited (16.7 and 9.1 percent, respectively).

With regard to these findings, there are two key points to note. First, gaps in the provision of written material were explained in part by the unavailability or limited availability of publications in the languages required. Some services consequently

produced their own material, a commendable but costly initiative that highlights an area where health service providers could be better supported in their work. Second, the heavy reliance on non-professional interpreting services was strongly attributed (in additional comments by respondents) to the cost involved. The fact that only 15 (11.4 percent) of the 132 health care services using some form of interpreter service paid for the service as a budget line item is significant; it indicates another resource area in need of attention, particularly in the light of clinical difficulties associated with the use of non-professional interpreters and the pressures placed on health service staff with linguistic skills. A useful first step in this area would be research into the current contractual agreements with primary health care services to determine the need for interpreter services and printed information for immigrant patients in the context of current costs to health professionals.

Immigrant staff – because of their ability (real or assumed) to directly provide and/or interpret for members of their own ethnic group and to educate or train other service staff – are clearly an important health service resource. It was found that:

- 55.5 percent of the respondents reported having business partners, colleagues or other staff who were recent immigrants, the percentage varying by service type (81 percent, emergency services; 60 percent, Plunket; 48 percent, general practices);
- most of the immigrant staff were employed as nurses (40 percent) and doctors (24 percent), with the remainder (36 percent) in either non-traditional health roles or administration;
- 77 percent of the respondents in services employing immigrant staff reported that such staff were used to assist in communicating with non-English speaking patients, the percentage being higher for Plunket (88 percent) than for either general practice or emergency services (71-72 percent).

Although supportive of their employment, some respondents (especially Plunket Nurses) were concerned that immigrant staff could be exposed to excessive demands and pressures as their linguistic/cultural skills were exploited by service personnel and members of their own ethnic groups. Obviously, the presence and use of immigrant staff may also divert attention from the recognised clinical need for professional interpreter services and dilute arguments for additional resources.

## **Recommendations**

With the above points in mind, the following aspects are in need of attention or consideration by the stakeholders concerned.

### ***For health and immigration services***

- Increased funding to allow for the greater time, professional interpreter services and printed information/pamphlets that are needed by primary health services in order to work more effectively with immigrant patients.



- Alignment of the services available to immigrant patients with the rights set out in the Code of Health and Disability Services Consumers' Rights.
- Further research to determine why immigrants appear to make more use of emergency medical services (including the costs of other primary health services in relation to incomes) in order to reduce the pressure on emergency services.

*For health professionals*

- Increased attention to cross-cultural health care, communication and cultural competence topics in all basic and continuing educational programmes (i.e. beyond established provisions for Maori and Pacific peoples) for health professionals to reflect the increasing diversity of New Zealand's population.

*For language and ethnic communities*

- Further research on and monitoring of the difficulties that immigrant patients experience in using health services, to enable problem areas to be identified and addressed.

## REFERENCES

---

- Abbott, M. W., Wong, S., Williams, M., Au, M. K. and Young, W. 2000: Recent Chinese migrants' health, adjustment to life in New Zealand and primary health care utilisation, *Disability and Rehabilitation*, 22(1/2): 43-56.
- Asian Public Health Project Team 2003: *Asian Public Health Project Report February 2003: Compiled by the Asian Public Health Project Team to Assess Asian Public Health Needs for the Auckland Region* (electronic resource, e-book), Ministry of Health, Wellington.
- Aye, A. M. M. T. and Guerin, B. 2001: Astronaut families: a review of their characteristics, impact on families and implications for practice in New Zealand, *New Zealand Journal of Psychology*, 30(1): 9-15.
- Bedford, R. and Lidgard, J. 1997: Arrivals, departures and net migration 19984/85-1995/96, pp.28-41, in Trlin, A. D. and Spoonley, P. (eds.) *New Zealand and International Migration: A Digest and Bibliography No. 3*, Department of Sociology, Massey University, Albany and Palmerston North.
- Bedford, R., Ho, E. and Lidgard, J. 2005: From targets to outcomes: immigration policy in New Zealand, 1996-2003, pp.1-43, in Trlin, A., Spoonley, P. and Watts, N. (eds.) *New Zealand and International Migration: A Digest and Bibliography, Number 4*, School of Sociology, Social Policy and Social Work in association with the New Settlers Programme, Massey University, Palmerston North.
- Bell, A., Starks, D., Davis, K. and Taumoefolau, M. 2001: Pasifika languages in the Manukau region at the 1996 Census, *New Zealand Studies in Applied Linguistics*, 7: 99-106.
- Bhopal, R. S 2006: The public health agenda and minority ethnic health: a reflection on priorities, *Journal of the Royal Society of Medicine*, 99(2): 58-61.
- Bihi, A. 1999: *Cultural Identity, Adaptation and Well-being of Somali Refugees in New Zealand*, M.Dev.Stud. Thesis, Victoria University of Wellington, Wellington.
- Bond, N. 2001: *The Role of Religion in the Resettlement of African Refugees in the Hutt Valley*, M.A. Thesis, Victoria University of Wellington, Wellington.

- Boyer, T. 1996: Problems in paradise: Taiwanese immigrants to Auckland, New Zealand, *Asia Pacific Viewpoint*, 37(1): 59-79.
- Briggs, L. 2001: Refugees and migrants: issues of multiculturalism in Aotearoa New Zealand social work, pp.85-96, in Connelly, M. (ed.) *New Zealand Social Work: Contexts and Practice*, Oxford University Press, Auckland.
- Cheung, P. 1993: Somatisation as a presentation in depression and post-traumatic stress disorder among Cambodian refugees, *Australian and New Zealand Journal of Psychiatry*, 27: 422-428.
- Cook, L., Didham, R. and Khawaja, M. 2001: The shape of the future: on the demography of Pacific peoples, pp.44-65, in Macpherson, C., Spoonley, P. and Anae, M. (eds.) *Tangata O Te Moana Nui; The Evolving Identities of Pacific Peoples in Aotearoa/New Zealand*, Dunmore Press, Palmerston North.
- Curren, M. 1997: Working with Asian peoples, pp.164-172, in Love, H. and Whittaker, W. (eds.) *Practice Issues for Clinical and Applied Psychologists in New Zealand*, New Zealand Psychological Society, Wellington.
- Davis, P., Lay-Yee, R., Maingay, S. and Gribben, B. 1997: Patterns of general practitioner usage among Pacific people: indicative results from the Waikato Medical Care Survey 1991-2, *New Zealand Medical Journal*, 110(1051): 335-336.
- Gherardi, P. and Tanoi, E. 1997: Working with Pacific Island peoples, pp.158-163, in Love, H. and Whittaker, W. (eds.) *Practice Issues for Clinical and Applied Psychologists in New Zealand*, New Zealand Psychological Society, Wellington.
- Hall, A. and Bishop, R. 2001: Teacher ethics, professionalism and cultural diversity, *New Zealand Journal of Educational Studies*, 36(2): 187-202.
- Henderson, A., Trlin, A. and Watts, N. 2001: Squandered skills? The employment problems of skilled Chinese immigrants in New Zealand, pp.106-123, in Starrs, R. (ed.) *Asian Nationalism in an Age of Globalization*, Curzon Press, Richmond, Surrey.
- Hill, J. and Hawk, K. 1998: Aiming for student achievement: how teachers can understand and better meet the needs of Pacific Island and Maori students, *Set*, 1998(2:4): 1-4.
- Ho, E., Au, S., Bedford C. and Cooper J. 2003: *Mental Health Issues for Asians in New Zealand: A Literature Review*, Mental Health Commission, Wellington.

- Ho, E. and Bedford, R. 1998: The Asian crisis and migrant entrepreneurs in New Zealand: some reactions and reflections, *New Zealand Population Review*, 24 (1/2): 71-101.
- Ho, E. and Lidgard, J. M. 1997: Give us a chance: the employment experiences of new settlers from East Asia, pp.126-132, in Morrison, P. (ed.) *Labour, Employment and Work in New Zealand: Proceedings of the Seventh Conference 28<sup>th</sup> and 29<sup>th</sup> November 1996*, Institute of Geography, Victoria University of Wellington, Wellington.
- Holt, R., Crezee, I. and Rasalingam, N. 2001: *The Communication Gap: Immigrant Healthcare in Aotearoa-New Zealand*, Auckland University of Technology, Auckland.
- Ip, M. and Friesen, W. 2001: The new Chinese community in New Zealand: local outcomes of transnationalism, *Asian and Pacific Migration Journal*, 10(2): 213-240.
- Kambaran, N. 2000: *Genitally Mutilated Women in the Wellington Region: A Study of Their Health Needs*, M.A. Thesis, Massey University, Palmerston North.
- Kinloch, P. 1985: *Talking Health But Doing Sickness: Studies in Samoan Health*, Victoria University of Wellington, Wellington.
- Loto-Su'a T. 1996: Can we cross the barrier? The role of cultural broker with Samoan clients, *Whitireia Nursing Journal*, 3: 17-26.
- Madjar, V. 2000: Bosnian refugees in New Zealand: their stories and life experiences, health status and needs, and the implications for refugee health services and policy, pp.3-43, in Madjar, V. and Humpage, L. *Refugees in New Zealand: The Experiences of Bosnian and Somali Refugees*, Working Paper Series, No. 1, School of Sociology and Women's Studies, Massey University, Albany, Auckland.
- Ma'ia'i, S. 1994: Cultural sensitivity and the Pacific Islander: a Pacific Island GP's perspective, *New Zealand Patient Management*, 23(11): 29-32.
- Metge, J. and Kinloch, P. 1978: *Talking Past Each Other: Problems of Cross-Cultural Communication*, Victoria University of Wellington, Wellington.
- Ministry of Health 2001: *Refugee Health Care: A Handbook for Health Professionals*, Ministry of Health, Wellington.

- Ngai, M. M. K., Latimer, S. and Cheung, V. Y. M. 2001: *Final Report on Healthcare Needs of Asian People: Surveys of Asian People and Health Professionals in the North and West Auckland*, Asian Health Support Services, Waitemata District Health Board, Auckland.
- North, N. 1995: *Crossing the Sea: Narratives of Exile and Illness Among Cambodian Refugees in New Zealand*, PhD Thesis, Massey University, Palmerston North.
- North, N. 1996: Purchasing and delivering health services for non-Western cultures, pp.66-76, in *Interhealth: Proceedings of the First International Conference on the Changing Face of Health Services Management in Asia and the Pacific Rim*, University of New South Wales, Sydney.
- North, N., Trlin, A. and Singh, R. 1999: Characteristics and difficulties of unregistered immigrant doctors in New Zealand, *New Zealand Population Review*, 25(1/2): 133-143.
- Pauwels, A. 1995: *Cross-Cultural Communication in the Health Sciences: Communicating with Migrant Patients*, Macmillan Education, Melbourne.
- Penton, R., Bedford, J., Fry, J., Kitchen, M. and Simpson, J. 2000: A whole-school approach to providing for NESB students in secondary schools, *Many Voices*, 16: 9-11.
- Selvaraj, R. 2001: Alcohol and drug treatment: issues and challenges in working with Asian clients, *Social Work Review*, 13(4): 25-33.
- Sim, J. P. 2001: *Meeting Refugee Needs: A Study of the Needs of People with Quota Refugee Backgrounds and How Those Needs Are Met in Manukau City, New Zealand*, M.Plan.Prac. Research Report, University of Auckland, Auckland.
- Spoonley, P. and Trlin, A. 2004: *Immigration, Immigrants and the Media: Making Sense of Multicultural New Zealand*, New Settlers Programme Occasional Publication Number 9, New Settlers Programme, Massey University, Palmerston North.
- Statistics New Zealand 2003: *New Zealand Census of Population and Dwellings, 2001*, Statistics New Zealand, Wellington, [www.stats.govt.nz](http://www.stats.govt.nz)
- Tamasese, K., Peteru, C. and Waldegrave, C. 1997: *Ole Taeoa Afua: The New Morning. A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services*, The Family Centre, Lower Hutt.

- Trlin, A. D. 1992: Change and continuity: New Zealand's immigration policy in the late 1980s, pp.1-28, in Trlin, A. D. and Spoonley, P. (eds.). *New Zealand and International Migration: A Digest and Bibliography, Number 2*, Department of Sociology, Massey University, Palmerston North.
- Trlin, A. D. 1997: For the promotion of economic growth and prosperity: New Zealand's immigration policy, 1991-1995, pp.1-27, in Trlin, A. D. and Spoonley, P. (eds.) *New Zealand and International Migration: A Digest and Bibliography Number 3*, Department of Sociology, Massey University, Albany and Palmerston North.
- Trlin, A. D. 2005: Bibliography 1995-2001, pp.122-335, in Trlin, A., Spoonley, P. and Watts, N. (eds.) *New Zealand and International Migration: A Digest and Bibliography Number 4*, School of Sociology, Social Policy and Social Work, Massey University, Palmerston North.
- Trlin, A. D. and Barnard, D. 1997: Bibliography 1990-1994, pp.93-178, in Trlin, A. D. and Spoonley, P. (eds.) *New Zealand and International Migration: A Digest and Bibliography Number 3*, Department of Sociology, Massey University, Albany and Palmerston North.
- Walker, R., Wu, C. W. D., Soothi-O-Soth, M. and Parr, A. (1998). *New Zealand's Asian Population: Views on Health and Health Services*, Health Funding Authority, Auckland.
- Whyte, B. 1995: Students who are new settlers, pp.364-389, in Fraser, D., Moltzen, R. and Ryba, K. (eds.) *Learners With Special Needs in Aotearoa/New Zealand*, Dunmore Press, Palmerston North.
- Wilson, J. J. and Everts, J. F. 1995: Psychological wellbeing in New Zealand's ageing population: implications for counsellors working in a multicultural society, *New Zealand Journal of Counselling*, 17(2): 51-58.
- Young, N. 1997: Pacificans' access to primary health care in New Zealand: a review, *Pacific Health Dialog*, 4(2): 69-74.

## APPENDICES

---

Appendix 1: Information Sheet

Appendix 2: Questionnaire

## Appendix 1

**NURSING DIVISION**  
Faculty of Medical & Health Sciences



### **IMMIGRATION AND PRIMARY HEALTH SERVICES INFORMATION SHEET**

The University of Auckland  
Private Bag 92019  
Auckland

Thursday 27 June 2002

#### **To: The Senior Clinician**

My name is Nicola North. I am an Associate Professor in the Faculty of Medical & Health Sciences at Auckland University, and I can be contacted on the address below:

**Nicola North, Associate Professor**  
Ph: (09) 3737599 ext. 2931  
E-mail: [n.north@auckland.ac.nz](mailto:n.north@auckland.ac.nz)  
School of Medicine, The University of Auckland  
Private Bag 92019, Auckland

I am approaching you to request your participation in a study about the implications of immigration for New Zealand's primary health services. This study concerns the capacity of New Zealand's primary health services to meet the needs of recent immigrants seeking health care, and the burden, if any, on the health services imposed by a growing and increasingly diverse population of recent immigrants. The extent to which immigrants themselves are being recruited into primary health service workforces is also investigated.

Four types of primary health services are selected to participate. These are: General Practices, Plunket Nurse services, private accident and emergency services and Emergency Departments of public hospitals. Only those services operating in Auckland and Wellington are included, for the reason that the bulk of recent immigrants settle in these two cities. Your service was identified through telephone listings, this information and questionnaire is being sent to all listed.

Any health professional working in the service who has a good knowledge of the service is invited to respond on behalf of the service. For the purposes of this survey, the definition of terms used are as follows:

- **'Recent immigrants'** refers to persons born outside of New Zealand who have settled here approximately within the last 10-20 years. The term includes voluntary immigrants, skilled and unskilled, and refugees. The questions concern the service's population of immigrant patients, not specific patients.
- **'Primary health services'** refers to first contact and primary level services, including public hospital emergency departments.

I appreciate that you are all very busy people and prone to being "over-surveyed". I have therefore kept the questionnaire as brief and straightforward as possible. There are three areas of interest about which you are being questioned:

- language and communication
- cultural differences affecting expectations and demands



- support and assistance (e.g. interpreter) available to you in dealing with specific challenges and demands of immigrant patients.

It should take you no longer than 20 minutes to complete the 25 item questionnaire (mostly options to tick). The opportunity is also offered to further discuss health issues affecting immigrant patients both in Section E and/or through an unstructured, open-ended interview. Please return the completed questionnaire to me in the self-addressed freepost envelope by the **9<sup>th</sup> August 2002**. You may request a copy of a summary report of the study by indicating your interest on the separate form and supplying your contact details. (This page will be separated from the questionnaire on receipt of the return envelope before collation of information.)

This research is one of a large number of studies carried out since 1998 as part of the “New Settlers Programme”, a major research programme investigating a wide range of issues concerned with the settlement of immigrants in New Zealand and the impact in New Zealand society. The name of the programme leader is Associate Professor Andrew Trlin, he can be contacted on the details below:

**Andrew Trlin, Associate Professor**

Ph: (06) 350 5700 ext. 2835

E-mail: [A.D.Trlin@massey.ac.nz](mailto:A.D.Trlin@massey.ac.nz)

School of Sociology, Social Policy and Social Work

Massey University, Private Bag 11-222, Palmerston North

The New Settlers Programme is funded by the Foundation for Research, Science and Technology through grants from the Public Good Science Fund. Our findings are reported to government and non-government organisations responsible for policy and other matters related to immigrants and their settlement in New Zealand, and published in academic publications.

After all questionnaires have been coded, the questionnaires (minus the last page with your name and address) will be stored in locked filing cabinets in a locked room at Massey University for a period of five years or until analysis of all research undertaken by the New Settlers Programme (whichever comes later), as required by research protocol.

As a participant in research you have a number of rights:

- First, you have the right not to participate in this study at all.
- If you do agree to participate, you have the right to decline to answer a particular question.
- You have the right to ask questions about the study at any time, and to contact myself or Associate/Professor Trlin about any concerns that arise during the study.
- Your participation is based on the understanding that you will not be identifiable in the report of the study.

It is assumed that filling in the questionnaire implies consent.

Yours sincerely,

Nicola North (Dr)

Appendix 2

**THE NEW SETTLERS PROGRAMME**

**IMMIGRATION AND PRIMARY HEALTH  
SERVICES**

**- QUESTIONNAIRE -**

**Please return in the self-addressed freepost envelope provided by  
9<sup>th</sup> August 2002.**

***It is assumed that filling in the questionnaire implies consent.  
You have the right to decline to answer any questions.***

***Please answer all questions whether or not you see immigrant patients at your service.***

## SECTION A

## General information about your service

**A1. [i]** Please indicate by ticking the appropriate box that best describes your service:

- (a) General practice ☐ 1
- (b) Plunket nurse ☐ 2
- (c) Private accident and emergency ☐ 3
- (d) Public hospital emergency department ☐ 4

**[ii] Please write down (as respondent) your **role/position** in the service (e.g. nurse manager, clinical director, etc.)**

**A2.** Please specify the **suburb** and **city** in which your service is located (e.g. Otara, Auckland; Newtown, Wellington).

**A3. [i]** Do patients whom you believe have recently immigrated to New Zealand (approximately within the last 10-20 years) use your service?

- (a) Don't know ☐ 1  
(b) None ☐ 2  
(c) A few ☐ 3  
(d) Several ☐ 4  
(e) Many ☐ 5

**[ii]** Please list what you believe are the most commonly represented countries (e.g. Tonga) *or* regions (e.g. Pacific Islands) of origin, up to five, of your patients whom you identify as immigrants, in order of demand on your service:

- (a) \_\_\_\_\_  
(b) \_\_\_\_\_  
(c) \_\_\_\_\_  
(d) \_\_\_\_\_  
(e) \_\_\_\_\_

(f) Doesn't apply to this service: we see no immigrant patients ☐

**A4.** Indicate how often immigrant patients (that you have identified in A3[ii]) generally are seen at your service. Please tick one response closest to your estimate:

- (a) Once or more a week ☐ 1
- (b) At least once a month ☐ 2
- (c) Every few months ☐ 3
- (d) Annually ☐ 4
- (e) Rarely or never ☐ 5

**For  
Office  
Use  
Only**

1

--	--

22

7

		10
		16

☐

9

**A5.** On a scale of [1] to [6], indicate how true each of the following statements is for your service, where:

[1] = definitely true, [2] = mostly true,  
[3] = mostly false, [4] = definitely false,  
[6] = doesn't apply, we see no immigrant patients.

- [i] Immigrant patients are no different from any other patient. ☐
- [ii] I find working with immigrant patients interesting. ☐
- [iii] Less time is needed with immigrant patients than with other patients ☐
- [iv] I find working with immigrant patients frustrating. ☐
- [v] Health services like this one are not adequately resourced to meet the demands of immigrant patients. ☐

**A6.** Are any of your business partners/colleagues/staff themselves recent immigrants?

Yes ☐ <sub>1</sub>

No ☐ <sub>2</sub> (go to Question 10).

**A7.** Please write down the **positions/roles** immigrant staff members/colleagues (fill as many as applicable):

- (a) \_\_\_\_\_
- (b) \_\_\_\_\_
- (c) \_\_\_\_\_
- (d) \_\_\_\_\_

**A8.** Please write down the **countries of origin** (as many as applicable) of immigrant staff members/colleagues:

- (a) \_\_\_\_\_
- (b) \_\_\_\_\_
- (c) \_\_\_\_\_
- (d) \_\_\_\_\_

**A9. [i]** Do immigrant staff members/colleagues assist in communicating with patients in languages other than English?

Yes ☐ <sub>1</sub>

No ☐ <sub>2</sub>

Don't know ☐ <sub>3</sub>

**[ii]** *If "yes"*, please write down the **language[s]**, up to three, most often encountered in which staff members/colleagues interpret:

- (a) \_\_\_\_\_
- (b) \_\_\_\_\_
- (c) \_\_\_\_\_

**[iii]** *If "yes"*, do immigrant patients you see prefer to consult a clinician who is him/herself from a similar background?

Yes ☐ <sub>1</sub>

No ☐ <sub>2</sub>

Don't know ☐ <sub>3</sub>

For  
Office  
Use  
Only

☐

☐ 20

☐
☐
☐
☐

☐ 25

☐
☐
☐

☐ 30

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

## SECTION B

### Language and communication

**B10. [i]** Do you provide written health information and pamphlets in languages other than English?

Yes ☐<sub>1</sub>

No ☐<sub>2</sub>

**[ii]** *If "yes", please write down (as many as apply) the languages you use most:*

(a) \_\_\_\_\_

(b) \_\_\_\_\_

(c) \_\_\_\_\_

(d) \_\_\_\_\_

(e) \_\_\_\_\_

**B11. [i]** Do you use interpreter services?

Yes ☐<sub>1</sub>

No ☐<sub>2</sub>

The need has not arisen in our service ☐<sub>3</sub>

**[ii]** *If "yes", which of the following services do you use (tick all that apply):*

(a) Telephone interpreter service ☐<sub>1</sub>

(b) Professional interpreter personally present ☐<sub>2</sub>

(c) Patient-arranged interpreter (e.g. relative or friend) ☐<sub>3</sub>

(d) Staff member (e.g. an orderly who speaks the language) ☐<sub>4</sub>

(e) Other [please specify] \_\_\_\_\_ ☐<sub>5</sub>

**[iii]** *If "yes", do you pay for the service through your budget?*

Yes ☐<sub>1</sub>

No ☐<sub>2</sub>

**B12.** On a scale of [1] to [5], indicate how true each of the following statements is for your service, where: [1] = definitely true, [2] = mostly true, [3] = mostly false, [4] = definitely false, and [5] = does not apply, we see no immigrant patients.

**[i]** At least once a month there are instances when I am unable to understand what the immigrant patient was saying to me. ☐

**[ii]** At least once a month there are instances where I am uncertain that the immigrant patient has understood what I said. ☐

**[iii]** At least once a month there are instances when I believe the immigrant patient has not followed instructions because of communication problems. ☐

**[iv]** At least once a month difficulties in communicating with patients who speak languages other than English/whose English is limited are stressful or frustrating. ☐

**[v]** At least once a month trying to communicate with patients who speak languages other than English/whose English is limited is time consuming. ☐

For  
Office  
Use  
Only

☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

65

- (a) The subject of cross-cultural communication was taught in professional education. ☐ 1
- (b) Our employer provides opportunities to develop/improve our skills. ☐ 2
- (c) I believe this is an area where continuing education is needed. ☐ 3
- (d) It is not of concern to our service. ☐ 4
- (e) It does not appear to be a problem to health professionals in our service. ☐ 5

- [illegible]

- [illegible]

## SECTION C

### Cultural differences affecting expectations and demands

Cultural differences and patterns will vary according to the immigrants' cultural origins. E.g. immigrants from England may be indistinguishable from "Kiwis", while immigrants from some Asian countries may stand out as different. Please answer the following questions in relation to immigrant patients whom you identified as the main users of your service (See A3[ii]).

		For Office Use Only
<b>C16.</b>	In your experience to what extent do the main population of immigrant patients you encounter in your practice use each of the following primary health services as intended by providers, where:	
	[1] = no different from other patients;	
	[2] = over-use;	
	[3] = under-use;	
	[4] = varies between patients;	
	[5] = don't know	
	[6] = does not apply, we have no immigrant patients.	
[i]	general practitioner	<input type="checkbox"/>
[ii]	private accident and emergency service	<input type="checkbox"/>
[iii]	public hospital emergency service	<input type="checkbox"/>
[iv]	plunket nurse service	<input type="checkbox"/>
[v]	nurse practitioner	<input type="checkbox"/> 70
[vi]	midwife	<input type="checkbox"/>
[vii]	community pharmacy (over-the-counter medicines)	<input type="checkbox"/>
[viii]	non-Western medicine (e.g. Chinese medicine)	<input type="checkbox"/>
[ix]	complementary/alternative medicine (e.g. chiropractic)	<input type="checkbox"/>
[x]	dental services	<input type="checkbox"/> 75
[xi]	other (please specify) _____	<input type="checkbox"/>
<b>C17.</b>	On a scale of [1] to [5], indicate how true each of the following statements is for the main population of immigrants that you encounter in your service, where:	
	[1] = definitely true, [2] = mostly true, [3] = mostly false,	
	[4] = definitely false, [5] = don't know and	
	[6] = does not apply, we have no immigrant patients:	
[i]	Immigrant patients express their concerns and symptoms differently from other patients.	<input type="checkbox"/>
[ii]	Immigrant patients are less likely to expect high-tech interventions (e.g. surgery, imaging) than other patients.	<input type="checkbox"/>
[iii]	Immigrant patients are less likely to expect a prescription than other patients.	<input type="checkbox"/> 80
[iv]	Immigrant patients are more likely than other patients to expect admission to hospital.	<input type="checkbox"/>
[v]	Immigrant patients are higher users of preventive care.	<input type="checkbox"/>
[vi]	Immigrant patients express frustration at waiting lists.	<input type="checkbox"/>
[vii]	Immigrant patients are frustrated that they can't go directly to a specialist.	<input type="checkbox"/>
[viii]	Immigrant patients complain about the cost of primary health care.	<input type="checkbox"/> 85
[ix]	Immigrant patients are less likely than other patients to believe your reassurances when there is nothing wrong.	<input type="checkbox"/>
[x]	Immigrant patients express their pain differently from other patients.	<input type="checkbox"/>

**C18.** How adequate do you believe is the preparation of the health professionals in your service to work with immigrant patients whose **cultures** differ from the New Zealand culture[s] you are familiar with (tick all that apply):

- (a) The subject of culture and cross-cultural health care was included in professional education. ☐ 1
- (b) Our employer provides opportunities to develop/improve our skills. ☐ 2
- (c) I believe this is an area where continuing education is needed. ☐ 3
- (d) It is not our concern. ☐ 4
- (e) It does not appear to be a problem to health professionals in our service. ☐ 5

For Office Use Only
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> 90
<input type="checkbox"/>
<input type="checkbox"/>

**C19.** Do you have anything to add to the issue of culture and cross-cultural health care in relation to immigrant patients? Please do so here:

**C20.** Do you have examples, positive or negative, that illustrate the issue of culture and cross-cultural health care in relation to immigrant patients using primary health services? Please share them with us:



## SECTION D

### Support and assistance available

In 2001 the Government announced revised immigration policy to encourage increased immigration of skilled immigrants. The majority are likely to settle in Auckland, followed by other metropolitan centres. Questions in the last section give you the opportunity to say how increased immigration might affect your service and resourcing and support you believe is needed.

**D21.** To what extent do you believe increased immigration will put pressure on health care services such as yours (tick one box):

- (a) No pressure at all ☐ <sub>1</sub>
- (b) Some pressure but we can manage ☐ <sub>2</sub>
- (c) Considerable pressure, but we will manage with support ☐ <sub>3</sub>
- (d) Enormous pressure, we can't cope ☐ <sub>4</sub>

**D22. [i]** What do you believe are the main sources of pressure in providing health services to increasing numbers of immigrant patients (tick all that apply):

- (a) language and communication ☐ <sub>1</sub>
- (b) cultural differences ☐ <sub>2</sub>
- (c) high demand for services ☐ <sub>3</sub>
- (d) different expectations of services ☐ <sub>4</sub>
- (e) access to alternative services ☐ <sub>5</sub>
- (f) understanding how to access NZ health services ☐ <sub>5</sub>
- (g) other (please specify) \_\_\_\_\_ ☐ <sub>6</sub>

**[ii]** If you have ticked more than one, please rank the three most important in order of importance: ☐

☐
☐

**D23.** Which of the following supports do you believe are required (tick all that apply):

- (a) professional interpreter services ☐ <sub>1</sub>
- (b) cultural database/expert advice ☐ <sub>2</sub>
- (c) higher level of funding for immigrant patients ☐ <sub>3</sub>
- (d) more health professionals from immigrants' backgrounds ☐ <sub>4</sub>
- (e) continuing education to better understand different cultures ☐ <sub>5</sub>
- (f) specialised immigrant health services ☐ <sub>6</sub>
- (g) other (please specify) \_\_\_\_\_ ☐ <sub>7</sub>

For  
Office  
Use  
Only

☐
☐
☐ <sub>95</sub>
☐
☐
☐ <sub>98</sub>
☐ ☐
☐ ☐
☐ ☐ ☐

105

☐
☐
☐
☐
☐ <sub>110</sub>
☐
☐ ☐

- D24.** Do you have anything to add to the issue of pressure experienced in relation to primary health services for immigrant patients, and support you believe is required? Please do so here:

- D25.** Do you have examples, positive or negative, that illustrate the issue of pressure experienced in relation to primary health services for immigrant patients? Please share them with us:

## SECTION E

### Optional Comments

**This optional section provides you with the opportunity to discuss specific health needs which commonly affect immigrant communities (please continue on back of page if needed).**

- E1.** In your service do you make special provisions for immigrant patients (please describe)?

---

---

---

- E2.** Do you make provision for female and male immigrant patients to see doctors of the same gender as themselves to discuss sensitive health topics (please explain)?

---

---

---

- E3.** Do you promote screening services including cervical smears and breast screening to your immigrant patients?

---

---

---

- E4.** Do you have immigrant patients at your clinic who have been subject to cultural practices or customs that are illegal within New Zealand (please detail)?

---

---

---

- E5.** Do you have immigrant patients at your clinic who have requested medical or surgical procedures that are not medically necessary (please detail)?

---

---

---

- E6.** Have you encountered a higher than usual level of mental health problems affect your immigrant patients, e.g. as a result of trauma or stress (please detail)?

---

---

---

- E7.** Have you encountered unfamiliar health problems, or a particularly high prevalence of health problems in immigrant patients e.g. HIV/AIDS, TB, communicable diseases, blood disorders, nutritional inadequacies and parasitology (please detail)?

---

---

---

---

***Thank you very much for completing this questionnaire.***

**If you would like to further discuss (in a personal face to face meeting or telephone interview) the subject of immigration and primary health services please write your name and contact details here:**

Yes, I would like an interview: [ ]

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

e-mail: \_\_\_\_\_

---

**If you would like to receive a summary of the results provide contact details here:**

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

\_\_\_\_\_

e-mail: \_\_\_\_\_

---

**For any further inquiries I can be contacted at the address below:**

**Nicola North, Associate Professor**

Ph: (09) 3737599 ext. 2931

E-mail: [n.north@auckland.ac.nz](mailto:n.north@auckland.ac.nz)

School of Medicine, The University of Auckland

Private Bag 92019, Auckland

***This sheet will be detached from the questionnaire, the  
anonymity of your response is ensured.***

## AUTHORS

---

### **Nicola North**

The Principal Investigator for this survey, Nicola was a founding member of the New Settlers Programme and is currently Associate Professor and Post-Graduate Co-ordinator in the School of Nursing, Faculty of Medical and Health Sciences, University of Auckland. Having formerly lectured in the Business Studies Faculty, Massey University, where she ran the post-graduate programme in health services management, Nicola has been involved in research on health systems and health workforce issues over many years. Reflecting her enduring research interest in international migration and its impacts on both the migrant and the host society, her PhD thesis explored aspects of the health of Cambodian refugees in New Zealand. Nicola is the Principal Investigator for the New Zealand Cost of Nursing Turnover study, and a researcher in the Te Riu o Hokianga programme.

### **Sarah Lovell**

Sarah completed her MSc in social geography at the University of Auckland with a thesis titled 'Cervical Screening Services: Women's Access Within South Auckland' (2002). She was a research assistant in the School of Nursing, Faculty of Medical and Health Sciences, University of Auckland, at the time the present survey was undertaken. Sarah assisted Nicola with data management, data analysis and drafting sections of the report. She left the position to take up a doctoral scholarship in Canada.

### **Andrew Trlin**

Programme Leader for the New Settlers Programme, Andrew is an Honorary Research Fellow in the College of Humanities and Social Sciences, Massey University, Palmerston North. His research interests are in the areas of social demography and social policy in contemporary New Zealand, but he is best known for his work on aspects of international migration. Andrew's publications in this field include: (as author) *Now Respected, Once Despised: Yugoslavs in New Zealand* (Dunmore Press, 1979); and (as co-editor) *Immigrants in New Zealand* (Massey University Press, 1970) and the series *New Zealand and International Migration: A Digest and Bibliography* (School of Social Policy, Sociology and Social Work, Massey University, 1986, 1992, 1997 and 2005). He has recently been appointed to serve as a panel member of the Human Rights Review Tribunal.

## SELECTED NEW SETTLERS PROGRAMME PUBLICATIONS (to April 2006)

---

- Henderson, A. 1998: Politics and policies: legislation and language, pp.142-158, in Panny, R. E. (ed.) *People-People-People: Proceedings, Comments, Essays. Third National Conference 1997. New Zealand Federation of Ethnic Councils*, New Zealand Federation of Ethnic Councils (Inc.), Christchurch.
- Henderson, A. 2003: Untapped talents: the employment and settlement experiences of skilled Chinese in New Zealand, pp.141-164, in Ip, M. (ed.) *Unfolding History, Evolving Identity: The Chinese in New Zealand*, Auckland University Press, Auckland.
- Henderson, A. and Trlin, A.D. 1999: New Chinese – changing characteristics: a New Settlers Programme profile, pp.41-56, in Moloughney, B. and Ng, J. (eds.) *Chinese in Australasia and the Pacific: Old and New Migrations and Cultural Change. New Zealand Conference of ASCADAPI (Association for the Study of Chinese and Their Descendents in Australasia and the Pacific Islands)*, University of Otago, ASCADAPI, Dunedin.
- Henderson, A. M., Trlin, A. D., Pernice, R. and North N. 1997: English language requirements and immigration policy in New Zealand, 1986-1997, *New Zealand Population Review*, 23(1/2): 19-44.
- Henderson, A. M., Trlin, A. D. and Watts, N. 2001: Squandered skills? The employment problems of skilled Chinese immigrants in New Zealand, pp.106-123, in Starr, R. (ed.) *Asian Nationalism in an Age of Globalization*, Curzon Press, Richmond, England.
- Johnston, R. J., Trlin, A. D., Henderson, A. M., North, N. H. and Skinner, M. J. 2005: Housing experience and settlement satisfaction: recent Chinese, Indian and South African skilled immigrants to New Zealand, *Housing Studies*, 20(3): 401-421.
- Lovelock, K. and Trlin, A. 2000: *The Immigration Industry in New Zealand: A Survey of Industry Characteristics, Services, Practices and Contemporary Issues*, New Settlers Programme Occasional Publication No. 3, New Settlers Programme, Massey University, Palmerston North.

- Nash, M. 2002: Social work provision in relation to immigrants, refugees and asylum seekers in New Zealand: some preliminary findings, *Social Work Review*, 14 (4): 26-31.
- Nash, M. and Trlin, A. 2004: *Social Work with Immigrants, Refugees and Asylum Seekers in New Zealand*, New Settlers Programme Occasional Publication No. 8, New Settlers Programme, Massey University, Palmerston North.
- North, N. and Higgins, C. 1999: The employment of immigrants in New Zealand: employers' perspectives and experiences, pp.423-435, in Tipples, R. and Shrewsbury, H. (eds.) *Proceedings of the Seventh Annual Conference of the International Employment Relations Association, Lincoln University, New Zealand, 13-16 July, 1999*, Applied Management and Computing Division, Lincoln University, Christchurch.
- North, N. and Trlin, A. 2004: *Immigrants in Business: A Study of Self-employed Immigrants and Their Businesses in New Zealand*, New Settlers Programme Occasional Publication No. 10, New Settlers Programme, Massey University, Palmerston North.
- North, N., Trlin, A. and Singh, R. 1999: Characteristics and difficulties of unregistered immigrant doctors in New Zealand, *New Zealand Population Review*, 25(1/2): 133-143.
- Pernice, R., Trlin, A. D., Henderson, A. and North, N. 2000: Employment and mental health of three groups of immigrants to New Zealand, *New Zealand Journal of Psychology*, 29(1): 24-29.
- Spoonley, P. 2005: Print media representations of immigration and immigrants, 1993-2003, pp.86-106, in Trlin, A., Spoonley, P. and Watts, N. (eds.) *New Zealand and International Migration: A Digest and Bibliography, No. 4*, School of Sociology, Social Policy and Social Work in association with New Settlers Programme, Massey University, Palmerston North.
- Spoonley, P. and Trlin, A. 2004: *Immigration, Immigrants and the Media: Making Sense of Multicultural New Zealand*, New Settlers Programme Occasional Publication No. 9, New Settlers Programme, Massey University, Palmerston North.
- Trlin, A. and Henderson, A. 1999: The effects and implications of unemployment among new Chinese arrivals: a report from the New Settlers Programme, pp.102-116, in Moloughney, B. and Ng, J. (eds.) *Chinese in Australasia and the Pacific: Old and New Migrations and Cultural Change. New Zealand Conference of*

ASCADAPI (Association for the Study of Chinese and Their Descendents in Australasia and the Pacific Islands), University of Otago, ASCADAPI, Dunedin.

Trlin, A., Henderson, A. and North, N. 1999: Effects of unemployment among skilled immigrants from India, *New Zealand Population Review*, 25(1/2): 1-25.

Trlin, A., Henderson, A. and North, N. 2004: Skilled Chinese and Indian immigrant workers, pp.205-219, in Spoonley, P., Dupuis, A. and de Bruin, A. (eds.) *Work and Working in Twenty-first Century New Zealand*, Dunmore Press, Palmerston North.

Trlin, A., Henderson, A., North, N. and Skinner, M. 2001: Personal connections and international migration in New Zealand: The importance of relatives and friends, *New Zealand Population Review*, 27(1/2): 1-25.

Trlin, A., Henderson, A. and Pernice, R. 1998: Asian immigration, public attitudes and immigration policy: patterns and responses in New Zealand, pp.227-248, 288-390, in Laquian, E., Laquian, A. and McGee, T. (eds.) *The Silent Debate: Asian Immigration and Racism in Canada*, Institute of Asian Research, University of British Columbia, Vancouver.

Trlin, A., North, N., Pernice, R. and Henderson, A. 1998: The New Settlers Programme: Encounters responses, policies: an introduction to a research project, pp.274-290, in Panny, R. E. (ed.) *People-People-People: Proceedings, Comments, Essays. Third National Conference 1997. New Zealand Federation of Ethnic Councils*, New Zealand Federation of Ethnic Councils, Christchurch.

Trlin, A. and Watts, N. 2004: Immigration policy and immigrant settlement: a flawed relationship at the turn of the millennium, pp.111-134, in Spoonley, P., Macpherson, C. and Pearson, D. (eds.) *Tangata Tangata: The Changing Ethnic Contours of New Zealand*, Thomson/Dunmore Press, Melbourne.

Watts, N. and Trlin, A. 1999: *Utilisation of Immigrant Language Resources in International Business, Trade and Tourism in New Zealand*, New Settlers Programme Occasional Publication No. 1, New Settlers Programme, Massey University, Palmerston North,

Watts, N. and Trlin, A. 1999: Company employment policies and practices in the use of immigrant linguistic and cultural skills, pp.255-262, in Morrison, P. S. (ed.) *Labour, Employment and Work in New Zealand 1998, Proceedings of the Eighth Conference November 26 & 27, 1998*. Institute of Geography, Victoria University of Wellington, Wellington.



- Watts, N. and Trlin, A. 1999: Cultural resources of immigrants and international business in New Zealand, *New Zealand Population Review*, 25(1/2): 119-132.
- Watts, N. and Trlin, A. 2000: Access and equity issues in employment and service provision for NESB immigrants in New Zealand public sector organizations, *Journal of International Migration and Integration*, 1(3): 331-350.
- Watts, N. and Trlin, A. 2000: Diversity as a productive resource: employment of immigrants from non-English-speaking backgrounds in New Zealand, *Social Policy Journal of New Zealand*, 15: 87-101.
- Watts, N. and Trlin, A. 2000: Diversity as a productive resource. Employment of immigrants from non-English-speaking backgrounds in New Zealand, *IMIS* [Institut für Migrationsforschung und Interkulturelle Studien]-*Beiträge*, 16: 51-63.
- Watts, N. and Trlin, A. 2000: *Employment and Service Provision for Immigrants from Non-English Speaking Backgrounds in Central and Local Government Organisations in New Zealand*, New Settlers Programme Occasional Publication No. 2, New Settlers Programme, Massey University, Palmerston North.
- Watts, N. and Trlin, A. 2000: The use of NESB immigrant resources and service provision in New Zealand's public sector organizations, *New Zealand Studies in Applied Linguistics*, 6: 1-22.
- Watts, N. and Trlin, A. 2002: Meeting the needs of immigrant communities: roles and activities of local authorities in New Zealand, *New Zealand Population Review*, 28(2): 203-219.
- Watts, N. and Trlin, A. 2005: Enhancing the productive potential of diversity: issues in the employment of immigrants, pp.107-121, in Trlin, A., Spoonley, P. and Watts, N. (eds.) *New Zealand and International Migration: A Digest and Bibliography*, No. 4, School of Sociology, Social Policy and Social Work in association with New Settlers Programme, Massey University, Palmerston North.
- Watts, N., White, C. and Trlin, A. 2001: *English Language Provision for Adults and/or Refugees from Non-English Speaking Backgrounds in Educational Institutions and Training Establishments in New Zealand*, New Settlers Programme Occasional Publication No. 4, New Settlers Programme, Massey University, Palmerston North.

- Watts, N., White, C. and Trlin, A. 2001: Immigrant and provider perceptions of ESOL learning environments, *TESOLANZ Journal*, 9: 84-97.
- Watts, N., White, C. and Trlin, A. 2002: Roles and responsibilities in English language provision for adult NESB immigrants and refugees, pp.51-77, in Prasad, R. and van der Walt, N. (eds.) *Vibrant Voices and Visions for Ethnic New Zealand*, New Zealand Federation of Ethnic Councils, Wellington.
- Watts, N., White, C. and Trlin, A. 2002: *Young Migrant Settlement Experiences and Issues in New Zealand: Two Perspectives*, New Settlers Programme Occasional Publication No. 6, New Settlers Programme, Massey University, Palmerston North.
- Watts, N., White, C. and Trlin, A. 2004: *The Cultural Capital Contribution of Immigrants in New Zealand*, New Settlers Programme Occasional Publication No. 7, New Settlers Programme, Massey University, Palmerston North.
- Watts, N., White, C. and Trlin, A. 2004: Perspectives on the cultural capital contribution of overseas-born students and staff in New Zealand tertiary education institutions, *New Zealand Journal of Educational Studies*, 39(2): 193-206.
- White, C., Watts, N. and Trlin, A. 2001: *Immigrant and Refugee Experience of ESOL Provision in New Zealand: Realities and Responsibilities*, New Settlers Programme Occasional Publication No. 5, New Settlers Programme, Massey University, Palmerston North.
- White, C., Watts, N. and Trlin, A. 2002: New Zealand as an English-language learning environment: immigrant experiences, provider perspectives and social policy implications, *Social Policy Journal of New Zealand*, 18: 148-162.